STATE HOSPITAL PAYMENT SYSTEMS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

SECOND SESSION

JUNE 23, 1982

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

97-561 O WASHINGTON : 1982 HG 97-105

3361-71

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WEDNESDAY, JUNE 23, 1982

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 1:36 p.m., in room 2221, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senators Durenberger, Chafee, and Bradley.

[The press release announcing the hearing and the opening statements of Senators Durenberger and Dole follow:]

[Press Release]

SUBCOMMITTEE ON HEALTH SETS HEARING ON STATE HOSPITAL PAYMENT SYSTEMS

The future of the Government's two largest health care programs—Medicare and Medicaid—will be the focus of a series of hearings before the Senate Subcommittee on Health, according to Subcommittee Chairman Dave Durenberger (R-Minn.).

In the last 6 years, Medicare and Medicaid have increased in cost from $27.5 billion to $67.9 billion. The subcommittee's hearings will examine proposals to hold down the cost to taxpayers while still providing quality health care to elderly and poor persons.

"We are at a crossroads in national health policy," said Durenberger, "There's a growing consensus among experts that changes are needed in the way we pay for health services. We have to build incentives to reward the efficient provider of health care as well as the individual who takes the time to become a wise consumer."

The first of the hearings will be held on Wednesday, June 23 at 1:30 p.m. in Room 2221 of the Dirksen Senate Office Building.

Hospital reimbursement issues will be the first major focus of the series, and that session will focus on the experience of States in designing payment systems to control hospital costs.

Senator Durenberger noted that, "a growing number of States have implemented some form of rate setting or prospective budgeting. There exists tremendous diversity among the States in the methods chosen, providing us with an opportunity to assess various options and the problems experienced by the States in implementing these systems. We have a great deal to learn from the States as we begin our own discussions on how the Federal Government might apply some of these lessons to the Federal level."

"A great deal of interest has been expressed in a prospective payment system for hospitals. The subcommittee shares this interest. Among the questions we will have to look at is whether such a system will encourage efficiency while still guaranteeing quality health care for patients."

Future hearings in the subcommittee's series will examine the role of the consumer in the health care marketplace, especially the use of cost-sharing, vouchers, or other incentives that encourage the individual to make wise health care choices. The subcommittee will also look at the role of the health care provider—physicians as well as nurses, psychologists and other non-physician providers—in delivering quality, cost effective care.

STATEMENT OF SENATOR DURENBERGER

Today we begin an extensive series of hearings on the future of the Medicare and Medicaid programs. From 1976 to 1982, the cost of these two programs increased from $27.5 billion to $67.9 billion—and that's only the federal share. There is almost universal agreement that the rate of these cost increases is unacceptable.

At the same time, there is almost universal disagreement over the causes and solutions for the cost problem. With one exception, there is virtual consensus that retrospective cost-reimbursement has all but destroyed the financial reasons for health providers to strive for efficiency. Although retrospective cost-based reimbursement is universally condemned, we have become so wedded to this form of payment that proposals for major change are generating strong expressions of concern. Any change in the status quo is disruptive, particularly if it threatens payment mechanisms for existing providers.

Even the relatively modest changes we're proposing this year in the Medicare 223 limits are causing a major stir in the hospital community. These changes are designed to encourage efficiency and minimize waste. But they will undoubtedly result in the reallocation of some resources, and hospitals are worried. Any change, even in the right direction, is tough to achieve.

There is widespread agreement among hospitals and other institutional providers, and policymakers that a move from retrospective cost reimbursement to prospective reimbursement makes a lot of sense. But there is a good deal of disagreement over the details of what such a system should look like.

Fortunately, we have the opportunity to study a variety of prospective reimbursement systems that have been implemented around the country. Providers and government officials in many states—some of whom we will hear from today—have learned a great deal from their years of experience in rate review and rate setting. In my state of Minnesota we have had a hospital budget review program operating for all the state's hospitals since 1975.

What all of these programs have in common is that they calculate rates of payment in advance, and those rates are paid regardless of the actual costs subsequently incurred by the institution. The programs are designed to realign incentives and motivate institutional providers to keep costs down.

Most of you know that I have been and continue to be a strong advocate of consumer choice and competition as a mechanism for better controlling medical costs. In the long-run, I believe the consumer is in a far better position to seek out and demand more efficient care than are government regulators. Not surprisingly, I'm interested in how prospective rate setting affects consumer choice and competition.

Of course, I'm also interested in the effectiveness of prospectively set rates in containing costs. Have hospital costs risen less rapidly where rates have been set prospectively? And if they have, why? Are hospitals being run more efficiently, are they shifting costs to other payors, or are hospitals forced to consume their capital base in order to remain financially viable? And what's happened to quality of care?

I am also interested in exploring the extent to which state rate-setting programs are the product of particular political and fiscal conditions within a state. I wonder whether a program, for example, which works in New York will work as well in Minnesota.

Most of you know that I am concerned about the effect of cost-shifting. This year as part of the budget we will cut the growth of program costs in Medicare and Medicaid, yet a good portion of these cuts may well result in cost-shifting rather than cost-containment. The Council of Community Hospitals in Minneapolis and St. Paul released a study showing that in the Twin Cities Metropolitan area, hospitals have already shifted $40 million in costs to private patients in reaction to government reimbursement policies. To the extent that this cost-shifting distorts price signals, it compromises the workings of a rational market. One of the attractions of a rate-setting program which includes all payors is that it can or should correct the cost shift.

On the other hand, externally-imposed rates which reduce or eliminate cost shifts may very well stifle beneficial competition. In a functioning market there's nothing wrong with providing discounts and special rates to certain buyers. That's the nature of private enterprise. Prospectively set rates may control cost-shifting at the expense of effective competition. It's an issue I'd like to explore.

For any reimbursement program to work well in the long run, it must move in harmony with the developing market forces being generated throughout the country. Prospective reimbursement rates should reward the efficient and send punitive signals to those which are not. And we don't want prospective rate-setting to simply

put hospitals into fiscal distress, thus forcing the next generation to rebuild what we don't pay for.

I'm most interested in learning more about state rate-setting programs, and I look forward to hearing from each of you today. Thank you.

OPENING STATEMENT OF SENATOR DOLE

The Nation's health care expenditures have been increasing at an alarming rate. The largest and most inflationary component of health care spending is hospital care, which accounts for about forty cents of every health dollar.

National hospital expenditures have risen from $13.9 billion in 1965 to $99.6 billion in 1980—an increase of 717 percent. The daily cost of a hospital stay has risen from $41 in 1965 to $256 in 1980—an increase of 620 percent. During this period we have also seen significant increases in hospital admissions, the length of stays, and the number of outpatient visits.

The Federal Government has tried to control these increases by a variety of approaches, such as cost limits, limits on the supply of facilities—in the form of certificate of need and planning legislation—and utilization controls. However, these programs have had only an indirect effect on the problem, and their impact lags far behind their implementation. As a result, more attention is being focused on alternative modes of hospital reimbursement—particularly prospective payment systems.

Currently, most hospitals are paid retrospectively for the services they provide. Retrospective payment systems are viewed by many experts as an important contributing factor to the increase in hospital expenditures. These payment mechanisms—whether based on costs or charges—are widely viewed as inherently inflationary, since they provide little or no inducement for hospitals to control costs or operate more efficiently.

Many States have established rate-setting programs, some as far back as the late 1960s. More than half the States currently have some type of rate review program. Almost all of these rate review programs involve the concept of prospective payment. It has been estimated that at least 25 percent of the Nation's hospitals are involved in varying degrees with prospective payment in one form or another.

The degree of variation among the different programs is great. We believe the experiences of the States and lessons they have learned from their programs provide an invaluable resource on which we can draw. Our purpose in conducting this hearing today is to learn from those experiences—both positive and negative—as we give further attention to the various methods of hospital reimbursement.

Senator DURENBERGER. The hearing will come to order.

Today we begin an extensive series of hearings on the future of the medicare and medicaid programs. I can't tell you how long that series will last nor the content of all of the hearings. It may never conclude. But it is a serious attempt to take a look at what this country has done over the last 17 to 18 years. We will seek recommendations on how the role of Government in meeting the health care needs of the people of this country should be changed.

From 1976 to 1982 the costs of the medicare and medicaid programs has increased from $27.5 to $67.9 billion, and that's only the Federal share. There is almost universal agreement that the rate of these cost increases is unacceptable to the people of this country. At the same time there is almost universal disagreement over the causes and solutions to the cost problem, with one exception: There seems to be a virtual consensus that retrospective cost reimbursement has all but destroyed the financial reasons for health providers to strive for efficiency.

Although retrospective cost-based reimbursement is universally condemned, we have become so wedded to this form of payment that proposals for major change are generating strong expressions of concern. Any change in the status quo, as everyone on this committee knows this year, is disruptive, particularly if it threatens existing providers.

Even the relatively modest changes we are proposing this year in the medicare 223 limits are causing a major stir in the hospital community. Changes are designed to encourage efficiency and minimize waste. They will undoubtedly result in the reallocation of some resources, and hospitals are worried. Any change, even in the right direction, is tough to achieve.

There is widespread agreement among hospitals and other institutional providers and policymakers that a move from retrospective cost reimbursement to prospective reimbursement makes a lot of sense. But there is a good deal of disagreement over what the details of such a system should look like.

Fortunately, we have the opportunity to study a variety of prospective reimbursement systems that have been implemented around the country. Providers and government officials in many States—some of whom we will hear from today—have learned a great deal from their years of experience in rate review and-rate setting. In my State of Minnesota we have had a hospital budget review program operating for all the State's hospitals since 1975.

What all of these programs have in common is that they calculate rates of payment in advance, and those rates are paid regardless of the actual costs subsequently incurred by the institution. The programs are designed to realine incentives and motivate institutional providers to keep costs down.

Most of you know that I have been and continue to be a strong advocate of consumer choice and competition as a mechanism for better control of medical costs. In the long run I believe the consumer is in a far better position to seek out and demand more efficient care than are Government regulators. Not surprisingly, I am interested in how prospective ratesetting affects consumer choice and competition.

Of course, I am also interested in the effectiveness of prospectively set rates in containing costs. Have hospital costs risen less rapidly where rates have been set prospectively? And if they have, why? Are hospitals being run more efficiently, are they shifting costs to other payers, or are hospitals forced to consume their capital base in order to remain financially viable? And what has happened to the quality of care?

I am also interested in exploring the extent to which State ratesetting programs are the product of particular political and fiscal conditions within a State. I wonder whether a program, for example, which works in New York will work as well in Minnesota.

Most of you know that I am concerned about the effect of cost-shifting. This year as part of the budget we will cut the growth of program costs in medicare and medicaid, and yet a good portion of these cuts may well result in cost shifting rather than cost containment.

The Council of Community Hospitals in Minneapolis and St. Paul recently released a study showing that in the Twin Cities metropolitan area hospitals have already shifted $40 million in cost to private patients in reaction to Government reimbursement policies. To the extent that this cost-shifting distorts price signals, it compromises the workings of a rational market. One of the attractions of a ratesetting program which includes all payers in that it can or should correct the cost shift.

On the other hand, externally imposed rates which reduce or eliminate cost shifts may very well stifle beneficial competition. In a functioning market there is nothing wrong with providing discounts and special rates to certain buyers. That's the nature of private enterprise. Prospectively set rates may control cost shifting at the expense of effective competition. That is an issue I would also like to explore.

For any reimbursement program to work well in the long run, it has to move in harmony with the developing market forces being generated throughout the country. Prospective reimbursement rates should reward the efficient and send punitive signals to those which are not. We don't want prospective ratesetting to simply put hospitals into fiscal distress, thus forcing the next generation of people to rebuild what we refuse to pay for.

I am most interested in learning more about State ratesetting programs, and I look forward to hearing from each of you today.

First we will hear from Robert Derzon, former bureaucrat, now vice president of—[laughter]—Lewin & Associates, Washington, D.C. Now an expert.

Robert, welcome.

STATEMENT OF ROBERT DERZON, VICE PRESIDENT, LEWIN & ASSOCIATES, WASHINGTON, D.C.

Mr. DERZON. Thank you very much for that gracious introduction, Senator. It is a pleasure to be here, really.

Today I am here representing only myself and my experience principally, first as a hospital director, and second as the first director of the Health Care Financing Administration. My job, as I understand it, is to give you an overview of prospective reimbursement, and its relationships to State ratesetting, and I will try to do that in the next few minutes. I have provided a statement which I would ask be filed in the record.

Senator DURENBERGER. Without objection, it will be.

Mr. DERZON. Today's hearing starts a series of discussions on prospective reimbursement of hospitals, and I like to think that what we are really asking is, What's the best way to purchase care from hospitals?

It is too bad, during the time I was in government and before that, that we have not brought this issue out for more discussion. As you know, medicare is a payment program wherein three-quarters of the dollars goes directly to hospitals. It is basically a hospital and doctor insurance program with the lion's share going to hospitals.

Hospital cost increases you have described; I need not go over that, except that they are clearly continuing to outrun the CPI, the ability of Government to generate revenues, the ability of the social security funds to gear up for the onslaughts against it with respect to hospital expenditures. Medicare's practice of paying retrospectively incurred costs has created strong incentives for hospitals to spend more, not less; and what is worse and is sometimes forgotten, I think, is that it encourages hospitals to believe that almost all capital investment is risk free—the expectation that

whatever they spend on capital will be either passed through or absorbed in cost-based reimbursement.

Now there are certain prospective payment programs that change these incentives to overspend and, as I have pointed out in my statement, may moderate the rates of cost increase in hospital expenditures. You will hear more about that today.

I really want to touch on four matters briefly and suggest that you and your committee members read the staff working paper on this subject. It is an excellent document that goes through the basic issues.

I do want to highlight, though, that there is a definition, a working definition, for prospective reimbursement that has been used; and, basically, what it says is that hospitals will know in advance what they will be paid for for their product or products regardless of the cost of producing that product. They will also know, by the way, whether this will apply to certain payer classes or all payers.

Last, they will be at risk if indeed their costs outrun these preestablished prices.

Now there is also an inference that hospitals at risk should be allowed to retain all or a portion of their savings below those target reimbursement rates, and that is something I hope you will examine closely with respect to the State programs that are now in existence.

The four matters I propose to touch on are: First, the objectives that are usually cited for a prospective program; second, some of the important criteria that one would want to see developed in most good prospective payment plans; a few key issues that I will touch on; and a caution.

Now, as far as objectives go, and I don't want to suggest that they are always met or that all of these are all of the objectives of all of the prospective programs that have been developed, but the advocates of prospective reimbursement say that Government can budget more effectively what it will spend on hospital services; and, second, that hospitals will know what they will have to spend and can make better investment decisions, better operating decisions because they know what finances will be available to them.

There is a suggestion, too, that cost-saving behavior will be rewarded or at the very least not penalized; and as you have pointed out, often in medicare if a hospital spends less money it in effect gets less money, a roughly 100-percent tax on saving the medicare dollar.

Some advocates suggest that hospitals can be motivated to reduce the intensity of acute care without hurting the quality of care. That depends a little bit on what the reimbursement program looks like.

Cost shifting—the problem you cited earlier—and market segmentation, that is, the ability of hospitals to sort out various purchasers of care, can be lessened or eliminated depending on the extent to which hospital costs or prices are averaged across all payer classes.

Some argue that prospective reimbursement allows States to get into the act, and indeed you have several States represented today. They are the locus of the more important experiments and demonstrations in prospective reimbursement.

Another reason for going toward prospective reimbursement is that it is possible to get some health care delivery reforms; in other words, change the system a little bit. There are prospective programs that can reassemble the distribution of health service resources in a community, and I think the Rochester experiment is an interesting example of one that does that.

One of the objectives that is often cited for prospective reimbursement is that it is the best opportunity to keep hospitals viable. I think that is a tougher objective to swallow; but I think that basically what those advocates believe is that when all payers pay about the same rates for equivalent services to hospitals, that there is less discrimination against the hospital, and the hospitals which have a bigger balance of underfinanced patients have a better chance of success. And indeed in the various State programs and in some of the State statutes you will see language that basically says one of the purposes of prospective payment is to keep hospitals viable.

Some believers in prospective reimbursement believe that it is compatible with competition—a subject that I know you are deeply interested in. They believe that it is possible to interject greater price competition among providers and insurers through prospective ratesetting. And one of the reasons they cite, of course, is that prospective price setting basically does set a price, a visible price—it can be a visible price—and therefore various buyers can see the difference in prices from institution to institution, and in fact we can inform the buying process as a result.

Of course, the last objective is one that is perfectly obvious. It's the flip side. It's one of the few ways you can move from cost-based reimbursement.

Now, you will hear a lot about the State programs, and I don't intend to go into those because I think you have people here who know more about it than I. But I do want to say that I think those of us who have watched these programs and have helped stimulate the program of State ratesetting—one of the jobs HCFA does have at the present time—can draw a few conclusions. And I have just drawn a few in this paper.

One is that reimbursement systems, prospective as well as retrospective, really do influence hospital behavior. We can look at several examples; I have drawn a couple here: 223 limits on routine costs not only does set a prospective target for routine costs, but it does allow hospitals to do all kinds of things to moderate the impact of that—build intensive-care-unit beds, I think one of the big results of the current 223, shift costs to ancillary-care services, and so forth.

Practically any formula is going to have impacts on the hospital. In my conversations with hospital administrators in States that have State ratesetting, they will tell me that State ratesetting has been beneficial, at least in some States, often not in New York because that is a tough program, but in other States they talk about the advantages to them of giving them leverage with their department heads in containing their expenditures. They talk about the ability to negotiate with organized labor more effectively because they only have a limited amount of money; and they talk about im-

proving their budget and accounting capacity. There is no question that in some of those States these have been some of the results.

Second, one can conclude—at least I have concluded—that all ratesetting in the various State programs, though it's called sometimes prospective, may not really be prospective reimbursement by the way I have defined it; because some of the plans, in my view, have not offered hospitals extremely strong incentives to save, nor have they allowed them to keep the savings. Further, they have penalized them in subsequent years for having performed well. So I think we have to be careful to recognize the differences in State ratesetting programs.

Third, I think that, as I will say later, State ratesetting is not going to solve all of the problems. State ratesetting has been productive; it has constrained the rate of increase in costs, I am convinced. There are disagreements about that, but I think these programs ought to be allowed to flourish. And if you will recall correctly, even during the Carter proposals for cost containment there were suggestions made to allow States to continue doing what a State was doing if in fact ratesetting was as successful as a cost-containment program for the Nation would be.

Just a few comments on how you know when you see a good prospective program. Let me just touch on a few critical elements:

What you really want to do in a prospective reimbursement program is affect hospital decisionmaking. You can't do that if people don't know how much they are going to have to spend a day or two before the beginning of the fiscal year in which they have to operate.

So, obviously, we have to have prospective rates set well in advance, probably, in my view, for more than 1 year's period, although there can be adjustments along the way—predictable ones. The program ought to be firm and durable. Part of the problem hospitals have is trying to outguess the regulators, and they don't take regulators very seriously because they are sure things are going to change next year. That does not affect hospital behavior.

There ought to be incentives in a program for efficiency, adjusters for differences in patient mix—and we know more about that now than we have ever known; it is not perfect but there are ways to adjust for differences in case mix—and some special provisions for educational and capital costs. You may note in my statement that I do not believe in cost passthroughs. I think cost passthroughs have hurt the reimbursement programs that we have. I know that's a touchy subject. And I've said the gains for 1 year should not limit the incentives for the next.

The program must be understandable, and some of our programs and even some of the proposed cost-containment legislation was beyond even my understanding of how it might work. Obviously, hospital behavior will not be affected unless it is a program that can be understood; and, of course, it has to be administerable.

One of the difficult problems in prospective reimbursement is its impact on utilization, and that's a very important element, as I will explain in just a moment.

I think a good program should encourage communitywide health cost savings by encouraging hospitals to effect cooperative service programs which are less duplicative. That can be done in a variety

of ways. Rochester does it with global budgeting, but there are other ways to do that.

Now just a few comments, if I may, on what I think are sort of three or four very critical questions, the first being whether we can have a national prospective program for all classes of payers at this point in time. I have said no. I don't think we know how to design that program at the present time, nor do I think we should design such a program. But we could design a prospective program for medicare and medicaid, and that should move ahead. That program would probably build off 223 by adding ancillary-cost limits, and that could be done on a per stay, not a per day, basis as the routine costs are. That should be done by grouping hospitals, which is the way 223 currently operates. My only suggestion would be that in a good prospective formula, low-cost good performing hospitals ought to be able to generate a surplus above their incurred, allowable costs. I have not heard that discussed very much, but I think that's the kind of incentive that hospitals need in order to perform more effectively.

Now, as a complementary course of action, the State programs are evolving toward all payer classes, and the Federal Government has been assisting in that process by giving waivers under the medicare program so that essentially the State sets rates for all payers including medicare. There is nothing wrong with that, provided the State can do an effective job. And, indeed, in the cases where this is being applied, I think it is working quite well.

If there is an immediacy in protecting all payers from the inflation in hospital services right now, it seems to me that about the only option available is the type of plan proposed either by the administration or by the various congressional committees which was really a prospective revenue ceiling, which did not reward hospitals for superb performance but it sure penalized hospitals that couldn't live within those limits. I think if one felt the urgency to do something about hospital costs immediately across the board, one might want to look at the criteria I suggested for prospective reimbursement and see how a program could be tailored to better fit those criteria.

The second issue around all prospective programs has to do with what is the product you want to pay for. Do you want to pay for a hospital day? A hospital stay? An individual lab service? An individual X-ray service? Outpatients? Or do you want to leave outpatients out and just keep inpatient services within that umbrella?

My preference today—and it could change; but basically my preference—is for a per stay reimbursement. There are risks in per stay reimbursement, but I think there are fewer risks in per stay reimbursement programs than in others, and I think more and more we know how to do it.

New Jersey and Maryland are two examples of programs that are at work. The New Jersey plan is not in my view applicable to the entire Nation, and we need time to see how that one works out. Maryland's program seems to be working quite well and is reducing lengths of stay and reducing the amount of ancillary activity per stay. It is having a positive effect, as far as I know.

I have said that I don't think you can treat prospective reimbursement as a stand-alone issue. I think you have to think about

other things that need to be done; because prospective reimbursement primarily gets at the price of the goods, it doesn't get at the volume issues. And the volume issues are very important.

Medicare patients—the ones that I am particularly concerned about and this committee is—average 3.7 days of care per person per year. But if you you look at the distribution around the country, you see that some areas have about 2 days of care per medicare patient and some have as high as 5 days. Now, there may be some age differences in those figures, but that's what is currently being reported out. Obviously these are differences in utilization patterns, and not all of them can be explained; but one looks at this problem and sees differences in lengths of stay that are rather extraordinary, and differences in rates of admission.

I think that if one wants to move toward prospective reimbursement that you have to bolster the system with other strategies. I have listed a few in this paper, basically:

First, trying to revise some of the fee schedules of physicians to provide incentives for outpatient services. We would have to make a departure from UCR and I think it's high time we do.

Second, medicare copayments, a very controversial subject. I think medicare copayments at the very nominal level might influence people's use of hospital services and physicians' ordering habits. I think, by the way, that we are going to have to make some provisions for the low-income aged if we do that.

Third, legislating a program that would encourage more medicare access to HMO's. There are bills pending now in the Congress that I think would be very helpful. And you have to make a decision, then, as to whether HMO's would be obliged to pay the same rate, as a class of payers, as others; or leave them out of the system and let them negotiate rates.

Fourth, I think there is a real problem in controlling hospital capacity. This is not a popular subject in this Congress; but, as I have said in my statement, the Government's problems with respect to agricultural surpluses, for example, are going to be small potatoes compared to the extra cost of financing excess hospital capacity and duplicative programs. At least with corn and wheat you know your price and may be able to sell the surplus, but with medicare we pay an indeterminate price to a hospital for a nonreturnable or nonresalable commodity at a cost which escalates with the level of inefficiency and excess assets.

Should the Federal Government support prospective ratesetting programs in the States? I think they should send technical assistance, not a lot of money. The States who want to do it will do it, and the Federal Government ought to assist and continue to study the problem and the progress that is being made.

I should point out that some States are more willing to do this than other States, because some States are more willing to adapt to regulatory frameworks; on the other hand even a State like Arizona has been willing to consider it. That's a State that wasn't interested in regulation except in the health area, and only in recent times.

One of the difficulties is that States with large numbers of hospitals have a real problem, and I think in the course of discussion you may want to sort out the differences between States with small

numbers of hospitals versus States with large numbers of hospitals. My impression is that the States with smaller numbers of hospitals can do a much more sensitive and accurate job of pegging and negotiating the rules, the prices, and so forth, the terms by which prices are determined.

I think the Federal Government, this Congress in particular, is concerned about whether ratesetting would preclude competition. I have already said something about this. I think it can be complementary to competition, but it does take one competitive element out, namely the ability of individual buyers to negotiate prices with individual sellers. That takes some curious turns. In New Jersey I am told, for example, that HMO's have to pay an average price. They feel discriminated against because they do more work out of hospital; so for the same diagnosis, they apparently have to pay the same price and can't get the benefit of their practice patterns. Those are the kinds of problems one has to deal with.

On the cautionary side, I think you realize that hospitals and their products are highly differentiated. And those differences affect the costs. When it comes to prices, hospitals set their prices based on their costs first, and then they need to determine their operating margins or their profits. Those prices therefore are set differently by different classes of hospitals. And if one simply moves to looking at prices as they are now, we have some problems; because some hospitals have very high markups off of costs and some have very narrow markups.

Another caution, is the fact that we have serious problems in hospitals that carry very high expenses for bad debts. That problem is growing not shrinking, and is a serious problem. New Jersey has solved that problem, as I understand it—and you may wish to ask them about that—by spreading that bad debt across all purchasers, if my information is correct.

But if we don't take care of that particular problem, we are going to see a collapse of a vital sector of the nonprofit charitable hospital group that does make a real commitment to the care of the underinsured and the uninsured.

In closing, I just mention that the American Hospital Association, as you know, has proposed a prospective reimbursement program. I think that's to be applauded. It is not a perfect set of ideas; but it is certainly a start, and other ideas are coming forward now.

Now, in the ideal world, hospitals are like any other industry which produces services. They would love to set their own charges unilaterally and expect that all buyers would pay for them. Some have even suggested the medicare beneficiaries should be entitled to an indemnity insurance program, not a service benefit, and should pay the difference between the hospital's rates and the Government allowance. In my view, as a person who is very much concerned with medicare and medicaid, that course of action would be tragic and would be a sop to the vagaries of hospital charge practices.

What would not be tragic would be a medicare incentive prospective program for beneficiaries that would pay the covered services in full except for modest patient copayments and allow hospitals which operate at lower comparable costs to retain surpluses and to

improve their services or to meet their charitable responsibilities to the poor and to the uninsured.

As I said, I don't think the Federal Government is prepared to deploy a prospective system at the moment; however, States are at work, additional States could be brought into the fold, and as States wish to garner all payers together under one umbrella to get sufficient leverage in the system, I see no reason why the Federal Government shouldn't waive its own and hopefully new incentive reimbursement program to add to that purchasing power in order to deal effectively with hospitals.

That is essentially what I came to say, and I thank you for the time.

[The prepared statement of Robert A. Derzon follows:]

TESTIMONY OF ROBERT A. DERZON
on
Prospective Reimbursement of Hospitals
before the
Subcommittee on Health of the
Senate Finance Committee
June 23, 1982

It is a pleasure to reappear before this subcommittee. I am Robert Derzon, first Administrator of the Health Care Financing Administration, a former hospital director at New York University Medical Center and the University of California Hospitals, and now a Vice-President of Lewin & Associates, a Washington based health policy and health management consulting group. I represent only myself and my experience. Those who know me well recognize that I am a strong proponent of the public and private hospital sector, but that I am equally determined that our hospitals do not price themselves beyond our population's ability to pay for care and our government's ability to pay. Hospitals do provide unique and essential services to all Americans and it is unavoidable that government programs for the aged and poor are paying and will continue to pay a spectacular portion of those essential services.

Today's hearing subject is prospective reimbursement of hospitals. The question you are addressing, simply stated, is how to purchase care from hospitals? Tragically, that question has been on the back burner for almost all of the sixteen years of Medicare and Medicaid - it should not have been.

The issue is vitally important to hospitals, their patients, and the tax-paying public at large. Today, about three-fourths of every Medicare dollar goes for hospital payments, making Medicare the largest

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single purchaser of hospital services. Medicare plus Medicaid represents one-third of all hospitals' income; a payment in 1980 of $35.8 billion to our short term acute care hospitals. Total government expenditures for hospital services -- encompassing monies paid by federal, state and local government units -- were $54.2 billion in 1980 and made up more than half of all funds received by the nation's hospitals. Hospital cost increases along with increases in nursing home expenditures have and are expected to continue to outstrip the CPI, and government and Social Security revenue growth. Medicare's practice of retrospectively paying incurred costs has created strong incentives for hospitals to spend more, not less; and what is worse, has encouraged hospitals to believe that almost all capital investment is risk free.

Certain prospective payment programs change the incentives to overspend and may moderate rates of cost increases. We have a wealth of experience with alternative prospective payment programs about which subsequent witnesses will testify.

Contrary to most beliefs, prospective payment for hospitals is not a brand new idea. In 1974, Bill Dowling found that there were 22 non-legislated separate schemes already operational. Additionally, in the early 1970's, hospital prices along with other prices on other goods and services were capped in advance by the Economic Stabilization Program. The wage-price board had also prepared but never implemented a Phase IV plan to pay hospitals prospectively on a per stay basis. Interestingly, price increases <u>but not hospitals' incurred cost increases</u> were successfully dampened during the wage-price control period.

Today I want to discuss four basic matters with you, as well as to urge your reading of your staff's working paper which describes the basic fundamentals of prospective reimbursement and its application in selected regions or states. I will only once reiterate that prospective

payment means hospitals will know in advance what they will be paid for their product regardless of their production costs; they will know which classes of payors will be obligated to pay those prices; and as a consequence, hospitals will be at risk if their costs outrun the pre-established prices. Hospitals at risk should be allowed to retain all or a portion of their savings if, in fact, their actual costs are less than their revenues. In contrast, today Medicare and Medicaid pay on the basis of allowed reasonable costs incurred for the "efficient production" of services.

The four matters I wish to present are:

1. The purposes or objectives of prospective reimbursement. In other words, when the government purchases hospital care on a massive scale, what are we trying to accomplish?

2. My judgment of the most important elements to build into a prospective payment plan.

3. Key issues that have to be resolved early on, and

4. A caution to observe, as you consider the many prospective payment alternatives, which though imperfect are less defective than the retrospective system the law now requires.

THE OBJECTIVES OF PROSPECTIVE REIMBURSEMENT

Proponents of prospective hospital payment argue that the following objectives can be met:

1. Government and other payors can budget their expenditures in advance.

2. Hospitals know their prospective income and will be able to make the short and long range investment and operating decisions to live within their available finances.

3. Cost saving behavior can be rewarded, or at the very least, not penalized. In Medicare today, if a hospital spends less, the hospital gets less (effectively a Medicare 100% tax on savings.)

4. Hospitals can be motivated to reduce the intensity of acute care where such care is appropriate.

5. Cost shifting and market segmentation can be lessened or eliminated, if all payors are required to participate and pay equivalent prices for equivalent services.

6. State flexibility can be maintained. States have played a major role in early prospective reimbursement demonstrations and have (at least currently) a Medicaid stake in costs. Individual state initiative can be enhanced in a revised national program to pay hospitals.

7. Health care delivery reforms can be induced by prospective payment schemes by rewarding regionalization, sharing of support services among hospitals, and promotion of non-inpatient alternatives to acute hospital care.

8. Access can be better assured, because essential hospitals can remain more viable if reimbursement is structured fairly.

9. Paradoxically, competition can be promoted. Despite the regulatory aspect of government involvement in establishing and operating prospective payment systems, such systems can be consistent with very real efforts to interject greater price competition among providers and insurors. Prospective prices could be used to inform the buying public of what each individual hospital's price or cost, on average, would be.

10. Last, but not least, prospective reimbursement can eliminate the current retrospective method which rewards increased spending and faulty over-investment decisions.

A brief comment is in order about these objectives. First, Congress, if it chooses to move toward prospective payment, must decide on which objectives are most important. The design of a prospective system hinges on which objectives matter. For instance, if all payers are going to pay equally, some Blue Cross plans which now receive large discounts from charges and even Medicare which disallows certain ordinary costs such as non-Medicare patient bad debts, could find that a prospective payment system would raise their payment obligations. In effect, discount purchasers could face higher short run costs, but total hospital expenditures might be more effectively managed.

We know that the several state programs were established for very specific objectives. In New York, Connecticut, and Massachusetts the intent was to curb the rate of increase in the unit price of services by certain payors. In Maryland, Washington State and Minnesota the objective was to control the rate of increase in overall expenditures for hospital services. In Washington, Maryland, and New Jersey, one goal was to eliminate payment inequities among payors and among hospitals. Maryland and Washington's history suggests these states really wanted to create an alternative to Federal management of hospital payment.

Today as you will hear there is considerable and unresolved debate over whether current prospective rate setting and rate review states have controlled hospital expenditures better than non-rate setting states. In more typical states charges set by the hospitals determine most payor prices except for Medicare, Medicaid and some Blue Cross plans which continue retrospectively to pay allowable costs. The conflicting evidence suggests to me that the mandatory rate setting states, as a group, started with higher hospital costs and have moderately tempered their increase. Some rate setting states with very stringent formulas, such as New York, can dramatically lower the rate of increase in hospital expenditures even to the painful point of closing down some providers.

In the 1972 Social Security amendments ~~DHHS~~ HEW was authorized to provide development funds to states interested in rate-setting. The states have tried a wide variety of approaches, from allowable inflation formulas to negotiated budget review. Rates have been set per diem or per case basis. Various adjustment and appeal mechanisms have been tried. Overall, however, experience in these state programs suggests the following:

- First, that all payment systems, prospective or retrospective, if they affect large portions of hospital's business, do influence hospital behavior. We know that when HCFA set 223 limits on only inpatient routine costs, hospitals built intensive care units which are excluded from routine costs and hospitals shifted costs to ancillary services and outpatient clinics. If a formula pays by the day, one can expect more hospital days and longer hospital stays. If we set a stringent rate for only Medicare and hospitals can get more from other buyers, they will shift costs before they cut costs.

- Second, not all rate setting is wholly prospective and some plans really do not offer hospitals strong incentives to save and to keep the savings.

- Third, any national program would be wise to recognize that current state rate setting efforts are worthwhile and should have a chance to develop further. They should be monitored closely by government evaluators because there are innovative ideas in most plans. ~~They are each~~ Each state program is somewhat different but all have had to address all of the ~~generic,~~ tough generic issues in reimbursement. That does not mean, however, that in every state Medicare waivers should be granted.

- Last, that there is increasing human capacity in the design and management of incentive prospective payment programs that can be tapped by others who are interested.

SOUND ELEMENTS IN A PROSPECTIVE PROGRAM

I wish to touch on a few criteria. I will warn you that they are obvious in concept; complex in application.

a. The program must be firm and durable. Hospitals will not make hard decisions if the formula is going to change every year or is likely to be abandoned. By necessity most state programs have taken several years of evolution.

b. Prices must be determined well in advance so management can plan accordingly. A two or three year planning cycle with stipulated inflation indicators would result in better hospital planning and budgeting.

c. There must be income incentives for efficiency, sufficient adjusters for differences in patient mix, and special provisions for educational and capital costs. Cost pass throughs should be avoided. The gains for one year should not limit the incentives for the next.

d. The program must be understandable to large and small hospitals. The authorized commission or agency must have a program which is administerable.

e. The program should encourage appropriate utilization practices and substitutes for expensive in-patient care.

f. The program should encourage community-wide health cost savings by encouraging hospitals to effect cooperative service programs which are less duplicative.

g. The program must protect the viability of a sufficient number of efficient, high quality providers.

KEY POLICY ISSUES TO BE DECIDED

Should all classes of payors (Medicare, Medicaid, Blue Cross, commercial carriers, self-pay patients) be subject to a single prospective payment program?

The answer is "no". We would not know how to design a program that could fit the nation. We could design a program with prospective features for Medicare and Medicaid. Such a program could build off 223 limits by adding ancillary costs/stay, weaving in a case mix adjuster, and allowing low cost hospitals within well defined groups to retain savings for efficient performance. That would be a departure from current retrospective reimbursement.

As a complementary course of action, state programs seem to evolve naturally toward all payor classes and most will eventually seek Medicare participation. The Federal government can make clear the circumstances under which it is willing to assign a state the responsibility for Medicare payment.

If there is immediacy in protecting all payors from the inflation in hospital services, then there seems to be few available options other than the types of plans proposed by the Administration and various Congressional committees in the 1977-1979 period when prospective revenue ceilings were set for all hospitals. Those plans, if dusted off, could be tested against the criteria discussed earlier and a revised program designed.

Which hospital product should be prospectively priced?

Hospitals produce hospital stays, days of care, and individual services such as X-ray or lab procedures, outpatient visits, home health visits, etc. A single payor or group of payors must decide its preference for a particular unit of purchase. Each has advantages and weaknesses; each can create undesirable utilization effects. We have the most experience in establishing prices per day; but price per stay seems to me to be the most promising, provided there is sufficient monitoring of the medical necessity of admissions and re-admissions. The price per admission can be established by group average; by adjustments for case mix and volume changes, and/or by taking historical cost and accepting a tolerable mark-up. Hospital prices for less expensive product alternatives to inpatient care could remain outside the prospective system.

What collateral activities to prospective reimbursement for inpatient care should be implemented?

Prospective rate systems address only one piece of the total equation of hospital costs -- namely a unit price. They only tangentially touch the other principal factors that big buyers are worried about -- days of care and number of stays. Different and more vigorous incentives than exist now can and should be put into place. Medicare patients on average use 3.7 days of care annually, but this ranges from below 2 days in some areas to as high as 5.4 days. Similar variations in hospital use are found for other groups. The cost difference attributable to utilization dwarfs the savings potential of the best prospective rate system. If one's goal is saving dollars, prospective reimbursement, in my judgment, should be accompanied by other supportive changes such as

- Revising fee schedules of physicians to provide incentives for out-of-hospital care, for case management, and for non-procedural medicine.

- Instituting modest Medicare co-payments in the hospital that will increase consumer price sensitivity but will not work an extreme hardship on those aged whose resources are limited.

- Legislating a program that would encourage more Medicare access to HMOs.

- Encouraging states to control hospital capacity. The Government's problems with respect to agricultural surpluses are going to be "small potatoes" compared to the extra costs of financing excess hospital capacity and duplicative programs. At least with corn and wheat, you know your price

> and may be able to sell the surplus; with Medicare, we pay an indeterminate price to a hospital for a non-returnable, or non-resellable commodity at a cost which escalates with level of inefficiency and excess assets.

The point, simply restated, is that prospective reimbursement should be in tandem with other policy initiatives.

Should the Federal Government provide support for prospective rate setting programs at the state or regional level? If it should, how could it do it?

We can start with the premise that a state will be more likely to enact prospective rate setting legislation if it feels the public is being punished by runaway hospital costs, or if there is a crisis in hospital financing. If Medicaid is federalized, there would be a drop in state interest, I suspect. State interest in rate setting is renewable when cost shifting intensifies to the commercials and the Blues and when the financing crisis hits inner city or rural hospitals. Nevertheless, some states may wish to move on their own in the direction of prospective reimbursement.

The large states are at a great disadvantage. They have several hundred hospitals and often have the highest per capita hospital costs. Program administration is much easier for states with under 100 hospitals; rate setting mechanisms are better understood, the hospital association can train its members, and if there is budget review, that task is manageable. Larger states such as New York and Massachusetts are constantly in court defending their agencies against charges of crude formulas, inequities in implementation, and inadequate due process.

The Federal government should assist states technically, not dissuade them, and adopt a clear policy that Medicare will opt into state machinery that works well. It should only opt into programs that have positive as well as negative incentives. Too many of our so-called "prospective programs" set cost limits but do not reward cost cutting. I would continue the experimental authorities and encourage HCFA to seek new prospective programs. State programs, in particular, take a few years to get off the ground.

Does prospective rate setting preclude competition?

Free market economists might say - "Yes, it's devastating". My view is different. Announcing prices ahead of time could move HMOs and insurors to use preferred provider hospitals within multi-hospital communities. The knowledge of price differences among hospitals could lead hospitals to try to reduce their costs and consequently their prices, a normal element of competition which is truly precluded by retrospective payment.

ONE CAUTIONARY NOTE

Hospitals and their products are highly differentiated. Those differences affect their cost structures. Hospitals frame their pricing strategies and determine their profit or operating margins depending upon ownership, the need for profit, and their aggressiveness in acquiring new capital. Certain hospitals have traditionally cared for the poor and the underfinanced -- that number of patients is increasing and these unfinanced costs, reflected as bad debts or charity, become expenses that show up on hospital operating statements. These differences in hospitals must also show up in prospective rate formulation. If not, we will witness the collapse of one vital segment of this industry.

CONCLUSION

Hospitals, which once supported but now oppose state direction, have until recently been silent on prospective reimbursement. The AHA is to be congratulated on initiating a Medicare proposal this year. Other ideas are coming forward. Obviously, in an ideal commercial world, hospitals would like to set unilaterally their own charges and expect that all buyers pay them. Some even suggest that Medicare beneficiaries should be entitled to an indemnity insurance program, not a service benefit, and should pay the difference between the hospital's rate and the government allowance. That course of action would be tragic in my view, and be a sop to the vagaries of hospital charge practices.

What would not be tragic would be a Medicare incentive prospective program for beneficiaries that would pay the covered benefits in full except for modest patient co-payments and allow hospitals which operate at lower comparable costs to retain surpluses to improve their services or meet their charitable responsibilities to the poor and underinsured.

At the Federal level, I do not believe the technology nor the stomach is available to do hospital rate setting for all payors. States and purchasers of care however should be encouraged to explore new ways to achieve savings of health dollars. States can use the leverage of formulating rates for all payors if that is a politically acceptable and a sound economic course of action. In those situations, the Federal government should set standards whereby it would waive its own incentive reimbursement program to add its buying power and leverage to a state body if that would lead to more effective care at lower cost.

Senator DURENBERGER. Thank you very much, Bob. Let me deal first with the issue of what the product is that we want to buy. To quote from an editorial in the Denver Post after Colorado quit rate-setting, as follows:

> The real problem clearly stems from the flawed conception of what the rate-setting commission could do. It was given the power and resources to make arbitrary rollbacks in charges while doing nothing to control the basic costs underlying those charges.

Although I'm not thoroughly familiar with the specific legislative authority Colorado was given, is that characterization generally true of ratesetting programs?

Mr. DERZON. When we had that wage and stabilization program from 1972 to 1974, where, remember, we controlled prices, we found that hospital costs went up very much as they always did—not quite as fast, but almost as fast—despite the fact that there were controls on input costs.

So one can argue that if you only control rates you don't really get at the problem of costs.

I think that the key to controlling costs is to get hospitals persuaded that they really are only going to have so much to work with; and that maybe two hospitals can get together and be under the same umbrella, so their costs could be joined together and essentially work toward a less expensive product. Hospitals must save costs. Once hospitals incur these costs I think ratesetters and the government feels absolutely obliged to pay for them. After all, most of our hospitals are in the nonprofit charitable category, they are community institutions, they have enormous lobby force, and we are just not going to be allowed to starve hospitals. I think that's evident. We don't want to. But the problem we have is that when hospitals incur costs, we feel we have to make them whole.

So, whatever formula we used—it can be rates; I think that most of the ratesetters have moved from at first budgeting costs to rate formulas; in other words, they have started with costs and then moved toward the rate side. The place to start, in my view on costs, in part is on capital, because I think capital costs are turning out to be one of the hidden costs that is really driving our health care expenditures.

Senator DURENBERGER. Are there other public policy considerations that we should be looking at in that connection? We have the problem of the nontax status of certain kinds of corporate entities; we have the situation relative to the tax-exempt nature of a bonding authority for hospitals; we have the special preference, in some cases, given a teaching hospital; we have a situation with regard to military hospitals and veterans' hospitals. If we look at hospitals in the large context, I take it there are other things in addition to rates that impact capital formation. Is that correct?

Mr. DERZON. Most certainly. I am going to avoid saying anything about VA policy, because I got in so much trouble in Government talking about the VA that I will leave that to others.

But on the tax-exempt issue, I think that that issue is a difficult one. It is to some extent made easier by the fact that the difference between taxable borrowing and tax-exempt borrowing has been narrowing.

I think that it sends the wrong signal out, though, that kind of legislation, because basically hospitals that are in tax-exempt status for a whole lot of purposes begin to worry about whether their tax exemption is, in fact, being jeopardized.

What is more bothersome is the fact that, regardless of at what rates the hospital borrows at, medicare will pay for it. So even if we got rid of tax-exempt bonding authority, it is highly likely that all it would do is raise the cost of medicare.

Senator DURENBERGER. Well, let me continue to explore the issue of a hospital as, in part, a physical facility. You talked in your presentation about States with few hospitals and States with many hospitals. To be blunt about it, how do we get rid of the inefficient hospitals?

Mr. DERZON. Well, there is no easy way.

Senator DURENBERGER. We, as a community, not as Congress.

Mr. DERZON. First of all, I think that there are going to be hospitals scattered throughout the country—and they are in rural Minnesota as they are in other rural areas. They are absolutely essential. And though they are small and underutilized, and so forth, they are there for good and valid purposes, and they are not the big expense end of the hospital system. If I remember correctly, something like 13 percent of the hospitals represent 50 or 60 percent of the expenditures of hospitals in the country; so maybe we shouldn't worry too much about some of the smaller rural hospitals for our discussion here.

But we do have an inordinate number of localities where there are too many hospitals. My view is that the only way one can productively do anything about it is to create reimbursement incentives for merger and consolidation. I think one way to get that started is to do it through a prospective reimbursement system.

Senator DURENBERGER. Doesn't the ratesetting process just tend to franchise existing institutions?

Mr. DERZON. Not necessarily. It depends on what you do. You could, for example, build into reimbursement programs incentives to merge in areas that are overcongested with hospitals. It is possible to do that. And in fact we even thought about doing that in the Carter proposals a while back.

If the revenue limits are tough enough, it might be possible for two hospitals to get together, be treated as a single provider, and actually find the economies to squeeze under a tight prospective limit.

Right now, though, there is nothing in the reimbursement programs that gives hospitals any resources in which to conduct that kind of a merger. In fact, we have just the opposite problem. We have big hospitals, or hospital systems, or hospital companies, paying extraordinary sums of money for beds and simply raising the depreciation base on which medicare has to reimburse. So we are doing exactly the opposite thing. We have a lot of capital out there, but it's not really working productively

Senator DURENBERGER. Then part of the answer to the problem of the inefficient hospitals is providing incentives for community solutions. I suppose when we get to Rochester, or maybe some other examples, that we will find out that other things take place

in the ratesetting process that are not always predicted in the law but that emerge as a community reacts to ratesetting.

Mr. DERZON. Sure.

You might ask—in New York there are 50 hospitals which were taken out of circulation between 1975 and 1980, if I am not mistaken, in New York State. Now, some of that may not be attributable to the effects of ratesetting, but I suspect that some are.

Senator DURENBERGER. The August 1980 HCFA study told us a number of things, but one of them was that mandatory ratesetting programs have a significantly higher probability of influencing hospital behavior than voluntary programs. Do you agree with that conclusion?

Mr. DERZON. That's what the statistics show, and I think they show it very strongly.

Senator DURENBERGER. Would one or the other be more practical on the Federal level, or in terms of a Federal reimbursement policy?

Mr. DERZON. Well, I think that it's hard to imagine a new medicare-reimbursement formula that wasn't applicable across the board unless a State could show that it could do as well or better. In my view, the only States that would be able to show that they could do as well or better are probably States with mandatory programs. So I think it's hard to imagine a sort of voluntary acquiescence to one payment system in medicare.

Senator DURENBERGER. Let me ask you a little bit about the issue of quality of care.

Normally you get at quality at least in part by talking about who has market leverage. If quality is all the same, then in a surplus market you have price leverage with a buyer, and in a short market you have leverage with a seller. And I take it we are dealing in a surplus market right now. I would be curious to know whether or not any of these programs in any way deal with the issue of quality of care.

Mr. DERZON. I would tell you that I haven't seen anything in the literature that studied the relationship of quality to prospective reimbursement, and I can only give you my sort of amateurish view of that issue.

It is always argued that if you squeeze hospitals on dollars that quality will take a bath. And yet very few people have ever been able to draw a relationship between hospital expenditures and hospital quality—mostly because very few people know how to measure quality of care in a hospital, and it really has to be done almost on a case-by-case basis.

What we find is that we have huge differences in practice patterns around the country, and that physicians practice different brands of medicine in different parts of the country, different ways of practicing. That accounts for some of these wide differences in lengths of stay, days per thousand, and so forth.

My feeling about it is, though, that very few people make a convincing argument that people do better in a hospital if they stay there a lot longer than the average person for the same kind of condition, the same degree of illness. So the argument that "more is better" has never been made satisfactorily.

When we have surpluses, as we do, we have different results, however. For example, we have very short stays and a big bed surplus in California. We still have very short stays there. That raises the unit cost of care, and California has one of the highest unit costs of care in the country.

On the other hand, some argue that, until you have shortages of beds, and so forth, you don't get changes in hospital behavior.

I think there is essentially a lot of conflicting evidence, but I guess where I come out on all of this is that increasingly physicians who are concerned about economics and concerned about the total cost of health care are finding less expensive ways to treat some of the kinds of patient problems that they used to treat in the acute care setting. Some of our best hospitals in the United States now do 35 percent of their total surgery on an outpatient basis. That's a big change, and nobody is shouting about quality.

So I think there is lots of room. And I think when you have incentives and pressures, and you bottle up the inpatient side a little bit, it gives people opportunity to find other substitutes.

Senator DURENBERGER. Let me conclude by asking you about your obsevations on the general scope of ratesetting. There is a recent study quoted in Hospital magazine indicating that the average annual growth of hospital expenditures in States without rate-review programs in 1980 was 13.7 percent compared with 13.6 in States with mandatory goals, and it indicates that the margin between the two groups of States has consistently narrowed since the 4.3-percent spread in 1978. Are we to accuse Hospital magazine of prejudice, or is there a trend like that developing in the country?

Mr. DERZON. I think that there may be others who are going to appear here today that know more about this last year of experience than I do.

First of all, there are very conflicting numbers on the relative performances of States with and without mandatory programs. On balance, at least through 1980—you have asked about 1981 over 1980, but at least through 1980—it is pretty clear to me that there was a greater dampening of the rates of increase of per capita costs, per stay costs, and various measures, pretty much across the board in mandatory States.

Now, the critics say that that is the way it ought to be, because these are the highest cost States to start with; so they feel that there is more fat. I think it is very early to make a final judgment about this year or last year or the years before. And the reason I say that is that the experience of ratesetting States requires a rather lengthy period of implementation, and it takes a few years before any impacts can really be attributable. Some of the ratesetters take credit for the first year, and the program wasn't even in effect yet.

So I think we have to be a little more patient about our conclusions as to whether or not one State is doing better than another. I think that the economists who operate in this area will tell you that in the first years of ratesetting you get very light savings, then you go through a period which is unknown at the moment where you get heavier savings; but then, down the road, things begin to average out, particularly if other States either come on

board or if the Government tries a new reimbursement program, or something else.

The biggest change I think was in 1978, the biggest gap between States with and without ratesetting. And I have the feeling that the reason for that was that in the States that had mandatory ratesetting, those hospitals were locked in. In all those other States, hospitals were behaving as you would expect they would behave—they were gearing up for cost containment. So they were, in my view, probably pumping up their costs, covering their bases for future periods.

So there are a lot of things that tend to confuse these numbers. Therefore, it seems to me, we are going to have to wait a few years before we draw a final conclusion. I would simply say that is certainly not an argument for overriding or preempting the State ratesetting programs that are going on. They are finding interesting ways to pay hospitals, and I don't know who else is.

Senator DURENBERGER. With some familiarity with that period of time, I would tend to agree with you. It's a lousy period of time to use statistics for or against anything.

Bob, thank you very much for your time and preparation and presentation. We appreciate it a lot.

Mr. DERZON. Thank you, sir.

Senator DURENBERGER. Next we have a panel consisting of Carl Schramm, vice chairman of the Health Services Cost Review Commission, State of Maryland; Robert Crane, director of Health Systems Management, State of New York, Albany, N.Y.; and James A. Block, M.D., president of the Rochester Area Hospitals' Corp., Rochester, N.Y.

Thank you very much for being here. Unless you have a favorite way of going, we will proceed as you were introduced.

STATEMENT OF CARL J. SCHRAMM, DIRECTOR, JOHNS HOPKINS CENTER FOR HOSPITAL FINANCE & MANAGEMENT, AND VICE CHAIRMAN, MARYLAND HEALTH SERVICES COST REVIEW COMMISSION

Mr. SCHRAMM. Thank you, Senator.

I am Carl Schramm. I am vice chairman of the Maryland Health Services Cost Review Commission and also director for the Center for Hospital Finances & Management at the Johns Hopkins Medical Institutions in Baltimore.

Senator, I have prepared written remarks for the record, but I would like to depart from them.

Senator DURENBERGER. All of your remarks will be made part of the record.

Mr. SCHRAMM. Thank you.

Senator, I will try to be very brief today. I want to essentially tell the story of Maryland briefly, then also present for your consideration some evidence from studies we have been doing at Johns Hopkins of the behavior of all six of the mandatory States relative to the States without mandatory ratesetting.

First of all, at the beginning in Maryland I think there was an important distinction which flavors the success of Maryland evermore. In our State the hospital association is an association of

trustees, people who in fact have the fiduciary responsibility for the hospital. It was this group that petitioned the State legislature along with the medicaid agency in the late sixties for legislation to establish a mechanism to control hospital costs in our State, using the methods of the State public utility commission in the State.

The theory, legally and economically, was that these hospitals could in fact be controlled in the marketplace much like other public utilities. With that in mind, the general assembly passed, in 1971, our enabling legislation, and the health services cost review commission was established with a 4-year starting period. I think that's critical. It was in those 4 years that the rate method was developed and that basic information was gathered which has served us well ever since.

In 1975 we began to regulate the 54 hospitals in Maryland. Our total budgets now are well over $1.5 billion, and our hospitals run the whole gamut representative of hospitals across the Nation. We have an 1,100-bed hospital at Johns Hopkins, an internationally famous medical teaching hospital, and we have a 38-bed hospital over on the Eastern Shore—a very small hospital—a hospital because of its geographic remoteness which is necessary, a hospital that runs at less than 50 percent occupancy, a hospital which by many accounts would be thought to be inefficient.

From the beginning our system of ratesetting in Maryland has attempted to accomplish three things. First of all, we have sought to develop a sense of efficiency in our State's hospitals. Second, we have striven after the equity principle, making sure that the system of ratesetting was equitable among all providers and equitable for all hospitals. And, third, we have attempted to insure the financial stability of our hospital industry.

First of all, the efficiency constraint. Obviously, the State established this system because it threw up its arms at the absence of any Federal direction which was effectively controlling either medicaid expenditures in the State budget or overall expenditures by the citizens of Maryland on hospital costs.

Thus, the first thing the commission set out to do was lower the observed rate of inflation in the cost of hospitals in our State.

I have put up here, Senator, a chart showing the 6 regulated States versus the 44 nonregulated jurisdictions. Underneath this chart, if you will excuse me for a minute, is the story for Maryland.

Now, this chart holds several lessons. First of all, it shows us that immediately after the regulatory authority vested in the commission in 1975 we began to have a marked effect. Every year since 1975 we have had a statistically significant, lower rate of inflation than the 44 nonregulated jurisdictions and certainly lower than the extrapolated growth that Maryland would have experienced.

Maryland, prior to the establishment of the cost review commission, experienced a higher than average rate of inflation and certainly higher than our neighboring jurisdictions—Pennsylvania, West Virginia, Virginia, and Delaware.

So the record in Maryland, is I think, clear. We have in fact kept the rate of inflation down, and we estimate the compounded savings to the citizens of Maryland over the last 5 years to be in excess of $200 million. One clear effect of this has been the return

to Maryland's members of Blue Cross/Blue Shield of several millions of dollars in reduced subscription costs.

Now, the second goal we sought was equity—equity both among hospitals and equity among payers. Using the section 222 jurisdiction of your 1972 amendments to title XVIII, Maryland was granted by HCFA a waiver which established the rates set by the commission as the rates set for all payers including medicare and medicaid.

Thus, from 1976 forward, the rates paid by cash-paying customers, by Blue Cross subscribers, by commercially insured patients, and by beneficiaries under both titles XVIII and XIX has been the exact same rate. This has permitted equity among payers, and I would submit has also established a system of equity among hospitals such that there is not the major problem of cost shifting observed in other States.

For example, we have in inner-city Baltimore a number of hospitals which deal with an inordinate load of medicaid patients and patients who are essentially charity and bad-debt patients. By establishing the major payers as an insurance pool, distributing payments equally by making the rate base equal among all hospitals, this bad debt load is shifted across all payers and through all hospitals. I think this is a signal achievement in Maryland, an achievement which has led us to the third goal, that is assuring the financial solvency of our hospitals.

One of the critical problems that came before the legislature in 1971 was the issue of inner-city hospitals in Baltimore facing overwhelming bad-debt experience that threatened the solvency of the hospitals—and in fact bankruptcy was pending in several of our hospitals.

By developing a system that shifted the load of bad debt across the payers and across the hospitals, we have established financial solvency throughout our system.

I have included, Senator, at appendix 3, a 10-year history of the bottom lines in Maryland. You see also in appendix 3 that throughout this period the bottom line in our hospitals has improved consistently. We in fact have a more financially solid industry than many other States and certainly much more solid than it was in Maryland before the commission took hold.

These, I think, are the achievements of Maryland. And I think the Maryland system in many respects preshadows the systems developed in the other six States. When we examine the other six States, and I will have to excuse myself again to switch charts—our five sister jurisdictions are, as you know, Connecticut, New York, New Jersey, Massachusetts, and the State of Washington. These six states have consistently reported significantly lower rates of inflation throughout what I call the "regulatory era," post-1975–76. These data, by the way, were first reported in the New England Journal of Medicine, and this very chart appeared last year in correspondence in the New England Journal of Medicine. The data used here are from the AHA and are the most current publicly available consistent data which we could bring to the Senate this afternoon.

Throughout this period from 1975–76 to 1980 we see a marked and statistically reduced rate of inflation in hospital costs in these

jurisdictions. I think this is the critical index to look at. I think this is the index that people are concerned about politically, and this is in fact the index that tells us accurately the size of the total budget committed to hospital costs across these six jurisdictions.

Senator, I would like to make only three final points. They are points that essentially anticipate criticisms that those of us who are on this panel involved in ratesetting hear constantly. I think they are important criticisms, criticisms you have undoubtedly heard and will hear in the future.

The first is that the six States where mandatory ratesetting is established or has been established were high-cost States to begin with; which is to say, the cost of a hospital stay was high relative to the other States. That in fact is true. In many respects that is exactly why you would expect the urgency to have emerged in those jurisdictions, and I think it is a worthwhile observation but one which is not as important in 1982 as it was in 1976; because the unregulated States, as a result of the discrepancy in the rates of inflation, are catching up very fast with the six regulated jurisdictions.

In fact, in Maryland last year our adjusted average cost of an inpatient day of care is now below the average for the United States. This, I think, shows exactly the phenomenon I am referring to.

Second, as I believe was also alluded to in that hospitals' article you asked Mr. Derzon about, it is often alleged that per capita costs in these States are going up higher or are higher than in the nonregulated jurisdictions. In response to this I think it is imperative that we point out that increases in per capita costs, in fact, are lower in these jurisdictions, and certainly it is the case in Maryland that per capita costs are lower than per capita costs in the United States.

Again, these are statistical nuances that critics point to to dismiss the overwhelming and statistically robust effect of the important indicator, which is the rate of inflation.

Third, many people point to the presence of hospital bankruptcies or hospital closures in the regulated States. As Mr. Derzon ably observed, the experience here is quite checkered. In fact, in Maryland we have had no hospital bankruptcies and continued strengthening of the financial base of our hospital industry.

The overwhelming evidence comes from New York on the question of hospital bankruptcies. And while Mr. Crane is to my right, I can't help but observe that over the last 5 to 10 years the State of New York has lost hundreds of thousands of citizens to outmigration. At the same time that the State of New York is closing elementary schools, high schools, and colleges, apparently the hospital industry thinks there is a sacrosanct limit on the number of beds that can be eliminated in that State. I think that is the important ball to keep our eye upon when the question of hospital bankruptcies is in the air.

Finally, in conclusion, I think the lessons of Maryland and the other five regulated States are applicable, as Mr. Derzon observed, across the Nation. I think this is true for a number of reasons.

The first is that the problem of hospital-cost inflation is not solely a national problem. In fact, both the economy and the hospital industry vary immensely from State to State. What was appli-

cable in New York and in Maryland in the early 1970's was not and is not applicable in some of the Southwestern jurisdictions with booming economies and a great influx of population.

Second, hospitals are financed, apart from medicare, principally by local enterprise and local economies. Thus, there is a particularly important role for State governments, for Governors, and for the local community and their power elites to control the growth of their hospital industries.

Third, I can't underscore enough the observation of Mr. Derzon that continued growth of the capital stock of our hospitals must be continually watched.

The last appendix I have included shows that if Maryland has had any trouble in containing the per capita costs in our State it is because over the last 5 years, in a State that has lost population, our health planning agency has permitted the construction of 1,500 new beds in this State. Given such a growing amount of real debt service to support, it is difficult to expect Maryland to achieve the significantly low rates of inflation in per capita expenditures being achieved by other regulated States.

Thank you very much for this opportunity.

[The prepared statement of Carl J. Schramm and answers to questions from Senator Durenberger follow:]

STATEMENT OF

CARL J. SCHRAMM

DIRECTOR, JOHNS HOPKINS CENTER FOR
HOSPITAL FINANCE & MANANGEMENT

AND

VICE CHAIRMAN, MARYLAND HEALTH
SERVICES COST REVIEW COMMISSION

BEFORE THE

SUB-COMMITTEE ON HEALTH

OF THE

FINANCE COMMITTEE

U. S. SENATE

JUNE 23, 1982

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE:

THANK YOU FOR THE OPPORTUNITY TO SPEAK TO YOU CONCERNING THE MARYLAND EXPERIENCE WITH PROSPECTIVE PAYMENT OF HOSPITALS AND ABOUT THE EXPERIENCE OF HOSPITAL RATE-SETTING IN GENERAL. FOR THE PAST 5 YEARS I HAVE SERVED AS A MEMBER OF THE HEALTH SERVICES COST REVIEW COMMISSION. I WAS APPOINTED IN 1977 BY ACTING GOVERNOR LEE TO FILL THE "ECONOMIST'S CHAIR" FIRST HELD BY MY DISTINGUISHED PREDECESSOR, PROFESSOR MANCUR OLSEN OF THE UNIVERSITY OF MARYLAND. LAST SUMMER GOVERNOR HUGHES REAPPOINTED ME TO A SECOND FOUR YEAR TERM.

IN ADDITION TO SERVING ON THE COMMISSION, MY PROFESSIONAL RESEARCH INTERESTS, PERFORMED AS A MEMBER OF THE FACULTY AT JOHNS HOPKINS, HAVE CONCENTRATED ON THE PROBLEM OF CONTAINING HOSPITAL COSTS. IN 1980, I WAS A MEMBER OF A TEAM OF RESEARCHERS WHO REPORTED THE RESULTS OF A STUDY OF THE RATE SETTING EXPERIENCE IN SIX STATES, INCLUDING MARYLAND, IN THE NEW ENGLAND JOURNAL OF MEDICINE. I HAVE APPENDED A COPY OF THAT ARTICLE FOR THE RECORD. (APPENDIX 1) OUR STUDY SHOWED THAT IN THE SIX STATES WHERE MANDATORY STATE INITIATIVES WERE IN PLACE, THE RATE OF INFLATION WAS CONSISTENTLY THREE TO FOUR PERCENT BELOW THE AVERAGE EXPERIENCED BY THE NATION AS A WHOLE AND BY THE UNREGULATED JURISDICTIONS.

TODAY I HAVE BROUGHT WITH ME A CHART SHOWING THE SAME COMPARISONS, ONLY UPDATED, WHERE YOU CAN SEE THAT THE EFFECT

STILL HOLDS. (APPENDIX 2)

THE KEY TO THIS SUCCESS IS RELATED TO THE METHOD OF SETTING HOSPITAL PRICES AND IN PROVIDING INCENTIVES FOR EFFICIENT MANAGEMENT. THE MARYLAND EXPERIENCE OFFERS THE VERY BEST EXAMPLE OF WHAT I MEAN.

IN 1971, THE MARYLAND GENERAL ASSEMBLY PASSED OUR ENABLING STATUTE. IT PROVIDES THAT COMMISSION-SET HOSPITAL RATES SHALL BE PROSPECTIVE IN NATURE AND REQUIRES THE COMMISSION "TO ASSURE ALL PURCHASERS OF HEALTH CARE HOSPITAL SERVICES THAT THE TOTAL COSTS OF THE HOSPITAL ARE REASONABLY RELATED TO THE TOTAL SERVICES OFFERED BY THE HOSPITAL; THAT THE HOSPITAL'S AGGREGATE RATES ARE REASONABLY RELATED TO THE HOSPITAL'S AGGREGATE COSTS; AND THAT RATES ARE SET EQUITABLY AMONG ALL PURCHASERS OR CLASSES OF PURCHASERS OF SERVICES WITHOUT UNDUE DISCRIMINATION OR PREFERENCE." THE COMMISSION BEGAN REGULATING HOSPITAL RATES IN 1975. IN 1977, WE ENTERED INTO A CONTRACT WITH THE HEALTH CARE FINANCING ADMINISTRATION WHICH PROVIDED A WAIVER OF MEDICARE AND MEDICAID REIMBURSEMENT PRINCIPLES. AS A RESULT, SINCE JULY 1, 1977, ALL PAYORS HAVE BEEN PAYING MARYLAND'S HOSPITALS ACCORDING TO RATES SET BY THE COMMISSION.

THUS, MARYLAND'S SYSTEM IS ONE OF PROSPECTIVE RATES COVERING ALL PAYORS AND ASSURING EFFICIENCY, SOLVENCY, AND EQUITY.

OUR SEVEN YEAR EXPERIENCE YIELDS SEVERAL IMPORTANT LESSONS. FIRST, AS NOTED, LIMITING HOSPITAL REVENUES THROUGH A PROSPECTIVE PAYMENT METHOD DOES LEAD HOSPITALS TO

SPEND LESS MONEY. FROM FISCAL YEAR 1975 TO FISCAL YEAR 1981, MARYLAND'S HOSPITALS HAD INCREASES IN COST WHICH AVERAGE 2 TO 3 PERCENT A YEAR LESS THAN THE NATIONAL RATE OF INCREASE. THIS CUMULATIVE SAVING OF ABOUT 17 PERCENT HAS OCCURRED WITH NO BANKRUPTCIES. THE CITIZENS OF OUR STATE HAVE ENJOYED APPROXIMATE SAVINGS OVER THIS PERIOD IN EXCESS OF $300 MILLION.

THE SECOND LESSON IS AS OLD AS REGULATION ITSELF. IN ANY REGULATED INDUSTRY, THE AGENCY MUST CONCERN ITSELF WITH THE HEALTH OF THE INDUSTRY IT REGULATES. I AM PLEASED TO INCLUDE AS AN APPENDIX TO MY TESTIMONY DATA COMPILED BY OUR STATE'S HOSPITALS SHOWING THAT THEY HAVE BECOME PROGRESSIVELY STRONGER FINANCIALLY DURING THE LAST TEN YEARS. (APPENDIX 3) HOW CAN THE APPARENT BENEFIT TO THE CITIZENS IN SAVINGS COEXIST WITH INCREASED OPERATING MARGINS IN OUR STATE'S HOSPITALS?

THE ANSWER LIES IN LESSON THREE. HOSPITALS RESPOND TO INCENTIVES IN THE PAYMENT SYSTEM. THUS, A RATE-SETTING SYSTEM MUST NOT MERELY BE DESIGNED TO PROVIDE A FLOW OF FUNDS, BUT MUST BE DESIGNED SO THAT DESIRED CHANGES IN HOSPITAL BEHAVIOR IMPROVE THE HOSPITAL'S FINANCIAL CONDITION WHILE HOSPITALS ARE AT FINANCIAL RISK FOR THE COSTS ASSOCIATED WITH UNDESIRABLE BEHAVIOR. WE HAVE ESTABLISHED MARKET-TYPE INCENTIVES WHICH ARE EXPRESSLY DESIGNED AS A KIND OF "VISIBLE HAND" TO REPLACE THE MIS-INCENTIVES WHICH ARE ASSOCIATED WITH COST-BASED REIMBURSEMENT.

UNDER COST-BASED REIMBURSEMENT, A HOSPITAL IS NOT

FISCALLY RESPONSIBLE FOR ANYTHING. IF IT SPENDS MORE IT GETS MORE. PRESENT MEDICARE SECTION 223 LIMITS ARE RELATIVELY MILD AND MANY HOSPITALS CAN IGNORE THEM. THEY ALSO DRIFT UPWARD WITH REALIZED, RATHER THAN APPROPRIATE, INCREASES IN COSTS. UNDER A COMPLETELY "PROSPECTIVE" PAYMENT SYSTEM, A HOSPITAL WOULD BE TOTALLY AT RISK FOR ALL FINANCIAL DEVIATIONS. FOR EXAMPLE, IF THE ACTUAL RATE OF INFLATION PROVED TO BE DIFFERENT FROM THAT PROJECTED, HOSPITALS WOULD BE AT RISK FOR THE MISPROJECTION. YET, NO PROSPECTIVE SYSTEM COULD HAVE FORSEEN THE ACUTE RISE IN THE PRICE OF X-RAY FILMS WHICH OCCURRED IN 1979 AND NO REASONABLE SYSTEM WOULD HOLD HOSPITALS ACCOUNTABLE FOR THE ASSOCIATED UNDERFORECAST OF INFLATION. ACCORDINGLY, A "PROSPECTIVE" SYSTEM SHOULD NOT BE ONE WHICH SETS FUTURE RATES IN CONCRETE, BUT RATHER ONE THAT SETS REVENUE CONSTRAINTS FOR EACH HOSPITAL AND ADJUSTS THEM ONLY ACCORDING TO PRE-ESTABLISHED METHODOLOGIES. A PARTICULAR HOSPITAL'S REVENUES ARE ADJUSTED ON A YEAR-TO-YEAR BASIS WITHOUT RECOGNITION OF ITS ACTUAL COSTS BEYOND THE SPECIFIC APPLICATION TO THE HOSPITAL OF THE PRE-ESTABLISHED METHODOLOGY (I.E., ADJUSTMENTS FOR VOLUME CHANGES, CASEMIX CHANGES, FUTURE INFLATION, MISFORECASTS OF PAST INFLATION, CERTIFICATE-OF-NEED PROJECTS, NEW GOVERNMENT REGULATIONS, ETC.). IN MARYLAND WE BELIEVE, WHENEVER POSSIBLE AND MOST CERTAINLY FOR LABOR, THAT INFLATION PROXIES FROM OUTSIDE THE HOSPITAL INDUSTRY SHOULD BE USED AS THE MEASURE OF INFLATIONARY PRESSURE IN THE MARKET PLACE. WE ALSO BELIEVE

THAT THE SYSTEM SHOULD ATTEMPT TO RESPOND TO CHANGES IN CASE MIX SO THAT HOSPITALS DO NOT HAVE INCENTIVES TO TRIVIALIZE THEIR ADMISSIONS OR TO AVOID PARTICULARLY SICK PATIENTS WHOM THEY ARE MEDICALLY EQUIPPED TO TREAT.

THE FOURTH LESSON IS THAT TOTAL SYSTEM COSTS CAN NOT BE CONTROLLED UNLESS THERE IS AN EFFECTIVE BRAKE PUT ON CONTINUED REAL GROWTH IN OUR HOSPITAL INDUSTRY. IN MARYLAND IN THE LAST FIVE YEARS WE HAVE ADDED NEARLY 1500 NEW BEDS IN A STATE WHICH IS LOSING POPULATION. THESE NEW BEDS ADD TREMENDOUSLY TO THE PER CAPITA COSTS OF THE SYSTEM AND ARE, IN ALL LIKELIHOOD, UNNECESSARY. SEE APPENDIX 4. EVERY DOLLAR MARYLANDERS SPEND IN SUPPORTING THE DEBT SERVICES ON A NEW BED IS MATCHED 12 TIMES OVER IN DEMAND FOR OPERATING DOLLARS. OUR ECONOMY SUFFERS FROM ALL OF THESE RESOURCES BEING DIVERTED TO NEEDLESS HOSPITAL SPENDING. FOR EVERY DOLLAR SO EXPENDED IS A DOLLAR NOT AVAILABLE FOR CAPITAL INVESTMENT, WHICH IS DESPERATELY NEEDED AND WHICH WILL YIELD WEALTH TO FUTURE GENERATIONS OF OUR CITIZENS.

MR. CHAIRMAN, THE STATE-LEVEL EXPERIENCE IN MARYLAND IS ENVIOUS. WE HAVE SUCCEEDED IN REDUCING THE RATE OF INFLATION, IN DAMPENING THE GROWTH OF PER CAPITA SYSTEM COSTS, AND IN STRENGTHENING THE FISCAL CONDITION OF OUR HOSPITALS. I BELIEVE THE LESSONS THE SENATE MIGHT FIND IN MARYLAND THAT ARE APPLICABLE TO THE NATION ARE MANIFOLD. FIRST, THERE IS AN IMPORTANT ROLE FOR STATE GOVERNMENT IN CONTROLLING HOSPITAL COSTS. SETTING ASIDE MEDICARE, THE SUPPORT OF OUR NATION'S HOSPITALS IS A LOCAL ENTERPRISE.

LOCAL PROGRAMS AND SOLUTIONS ARE OFTEN BETTER THAN THOSE THAT ARE FEDERALLY-IMPOSED. THE RECORD IN REGARD TO SIX STATE EXPERIMENTS IS INCONTROVERTIBLE EVIDENCE OF THIS.

SECOND, THE DEMAND FOR COST CONTAINMENT PROGRAMS VARIES ENORMOUSLY FROM STATE TO STATE. IN JURISDICTIONS WITH ROBUST ECONOMIES THE PROBLEM IS LESS CRITICAL THAN IN STATES WITH STAGNANT ECONOMIES AND MORE POOR PEOPLE TO LOOK OUT FOR.

FINALLY, STATE EFFORTS, IN ORDER TO BE SUCCESSFUL, MUST ENJOY THE SUPPORT OF GOVERNORS, STATE LEGISLATURES, AND THE REGULATED INDUSTRY. THE COMMONWEALTH MUST BE ADVANCED IN TERMS OF A REDUCED FLOW OF REAL RESOURCES TO HOSPITALS AT THE SAME TIME WE ENSURE THE FINANCIAL SECURITY OF OUR NATION'S VERY PRECIOUS HOSPITAL SYSTEM. ONLY PUBLIC EFFORTS WILL PRODUCE THE SHORT TERM GUIDANCE NEEDED TO ACHIEVE BOTH GOALS BY INCREASING EFFICIENT BEHAVIOR IN HOSPITALS WHERE EXISTING PAYMENT SYSTEMS ENGENDER SENSELESS RESOURCE UTILIZATION. I HAVE INCLUDED, FOR THE RECORD, A MODEL STATE ACT WHICH I HAVE DRAFTED, WHICH IS DESIGNED TO ACHIEVE THESE GOALS. I ENCOURAGE THE SUBCOMMITTEE TO EXAMINE THE STATE EXPERIENCE CAREFULLY AND TO STIMULATE THE PROLIFERATION OF STATE EFFORTS IN THIS FIELD BY OFFERING TO SHARE SAVINGS TO THE FEDERAL MEDICARE BUDGET WITH THOSE STATES SUPPORTING EFFORTS TO CONTROL THE INFLATION OF PRICES PAID BY HCFA, AND BY SUPPORTING TECHNICAL ASSISTANCE TO LEGISLATURES AND GOVERNORS IN ESTABLISHING NEW STATE PROGRAMS.

THANK YOU.

SPECIAL ARTICLE

HOSPITAL COST INFLATION UNDER STATE RATE-SETTING PROGRAMS

BRIAN BILES, M.D., M.P.H., CARL J. SCHRAMM, PH.D., J.D., AND J. GRAHAM ATKINSON, D.PHIL.

Abstract Evaluations of the early phases of state efforts to control hospital costs led to discouraging conclusions about the effectiveness of such programs. To determine whether cost regulation has improved since then, we compared the experience of the six states that have comprehensive, legally mandated hospital rate-setting programs with that of the states without such programs during the period from 1970 to 1978. During the last three years of this period, the average annual rate of increase in hospital costs in rate-setting states has been 11.2 per cent, as compared with an average annual rate of increase of 14.3 per cent in states without such programs ($P<0.05$). We conclude that much of the initial pessimism regarding the effectiveness of hospital rate-setting programs, based on studies that covered earlier reporting periods, may be unwarranted. (N Engl J Med. 1980; 303:664-8.)

OVER the past decade, a number of states have established programs to set hospital rates on a prospective basis as a response to rapid increases in health-care expenditures. During this period, several authorities have viewed the evidence on the effectiveness of these programs as inconclusive.[1-4] In a recent survey article, for example, Hellinger states: "Although firm conclusions regarding rate-setting programs should not be drawn from existing evaluations, few policy makers feel that state rate-setting commissions are capable of controlling health-care costs."[5] Others have taken a disparaging view of the ability of these regulatory agencies to limit increases in health-care costs in general.[6] Enthoven captures the view of the pessimistic observers in his comment: "The weight of evidence, based on experience in many other industries, as well as in health care, supports the view that such regulation is likely to raise costs and retard beneficial innovation."[7]

Because most studies of the effectiveness of hospital rate-setting programs are based on their performance before 1975, when many programs were still in their early phases and were not yet regulating actively, more recent data are required for a valid assessment of the effectiveness of the programs. Data for the period from 1970 to 1978, presented here, show that substantial reductions in the rate of increase in the cost of a hospital stay can be attributed to the cost-containment programs.

STATE PROGRAMS

According to the traditional reimbursement system, hospitals are paid after services are rendered, either on the basis of a schedule of charges (charge reimbursement) or, for selected third-party payers, at the actual cost of the service (cost reimbursement). In contrast, prospective rate-setting programs attempt to set the amount that hospitals can charge for services before the period for which the rate is to apply.

From the Johns Hopkins Center for Hospital Finance and Management and the Maryland Health Services Cost Review Commission (address reprint requests to Dr. Schramm at 615 N. Wolfe St., Baltimore, MD 21205).

Supported in part by the John A. Hartford Foundation and the Robert Wood Johnson Foundation.

The approximately 25 prospective rate-setting programs now operating in the United States vary in authority, from mandatory rate setting by a legislatively established public agency to advisory budget review by nongovernmental associations. In addition, programs differ in the types of payers whose rates are subject to regulation — ranging from only Medicaid patients to all payers (Medicaid, Medicare, Blue Cross, commercial insurance, and out-of-pocket payers).

For this analysis, states are classified as rate-setting states only if they meet the following criteria: the rate-setting program is operated directly by a state agency, compliance by hospitals is mandatory, a majority of non-Medicare hospital expenses are subject to regulation, and the agency has been regulating rates actively since 1976 or earlier. The six states that meet these criteria are Connecticut, Maryland, Massachusetts, New Jersey, New York, and Washington. Although a majority of non-Medicare hospital expenses are affected by rate setting in each of the six states, the states vary in the coverage that their programs provide. The types of coverage range from that of Connecticut, where rate setting applies only to persons with commercial insurance and persons who pay out of pocket, to those of Maryland and Washington, where rate setting applies to everyone.

In these states, the appropriate state agency establishes daily rates as well as a schedule of rates for the other revenue centers (e.g., laboratory, operating room, and radiology) in each hospital. These become the only schedules that the provider may use to compute bills. Thus, the hospital's annual operating budget may be computed by multiplying the projected volume of standardized units that are delivered in each revenue center by the schedule of rates. Payers pay the provider for services rendered to subscribers according to the schedule. This renders the traditional distinctions among costs, charges, and reimbursement irrelevant. For this reason, we use the term "expense" to refer to money actually paid to the hospital. Some states allow discounts from the scheduled rates to Blue Cross and Medicaid because of economies of scale in processing claims, certain contractual assurances to pay without challenge, and promptness

Table 1. Delayed Regulatory Activity in Six Rate-Setting States.*

State	Year Statute Enacted	Year Agency Began to Regulate
Connecticut	1973	1976
Maryland	1971	1975
Massachusetts	1968	1975
New Jersey	1971	1974
New York	1969	1971
Washington	1973	1975

*Excludes six states with rate-setting programs that do not meet the listed criteria. In Arizona, Minnesota, and Wisconsin, participation in the review process is mandatory, but compliance with the proposed rates is voluntary. Rhode Island's program is a mandated process of negotiation and contract among the state government, Blue Cross, and the hospitals. Colorado's early program was restricted to Medicaid patients, and although comprehensive rate-setting legislation was enacted in 1977, controls were not imposed until 1978. Illinois, which passed enabling legislation in 1978, has not yet begun to regulate rates. (Source: interviews with state agencies.)

of payment. Table 1 lists the year of passage of rate-setting legislation and the year in which regulation effectively began in each rate-setting state. The periods between the year of legislation and the year when regulation became effective reflect start-up periods of various lengths.

In order to examine the impact of state rate-setting programs on the rate of increase in hospital costs, this analysis compares the rates of increase in expense per equivalent admission for community hospitals in the six rate-setting states with those rates for hospitals in the 44 non-rate-setting states and in Washington D.C. during the years 1970 to 1978.

Data

Data for this study were drawn from the past 10 annual surveys of the nation's hospitals conducted by the American Hospital Association (AHA) and published in the 1970 through 1979 editions of the AHA's *Hospital Statistics*.[8] The survey questionnaire, which is sent to all hospitals registered in the United States, is usually returned by more than 90 per cent of the hospitals.

We took the raw data from tables in the annual editions of *Hospital Statistics* and obtained the number of admissions and the total expenses for community hospitals in the individual states and in the United States as a whole from the tables entitled "Utilization, Personnel, and Finances." For 1972 and subsequent years, the data are presented as a total for the nation in Table 5A of the series and by state in Table 5C; for the years before 1972, these data are presented in Table 3. Inpatient gross revenue data for community hospitals were obtained from the table entitled "Revenue for Community Hospitals." This table is now presented as Table 11 of *Hospital Statistics* and was presented before 1972 as Table 8.

The category of "community hospitals" was chosen to represent the kind of hospital typically subject to state regulation. Community hospitals denote all nonfederal hospitals except psychiatric institutions, tuberculosis hospitals, long-term general hospitals, and other special hospitals. The category includes nongovernmental, nonprofit hospitals, investor-owned, profit-making hospitals, and state and local governmental hospitals. After 1970 the AHA narrowed its definition of community hospitals to exclude "hospital units of institutions," primarily prison and college infirmaries. This change decreased the size of the category by less than 1 per cent and does not affect the results of this study.

The expense per inpatient admission and the expense per inpatient day are the two measures of hospital output that are used most often to measure the major goal of state cost-containment programs — reduction in the rate of increase in inpatient costs. The fact that hospitals can maintain or increase current levels of spending and still show a reduction in per diem costs by extending the average length of stay limits the value of the per diem expense as a measure of cost savings. Therefore, we chose the expense per equivalent admission, which reflects the average cost of treating each hospitalized patient, as the best index with which to compare rates of cost increase in rate-setting and non-rate-setting states.

Methods

In order to study the effect of state rate-setting programs on the rate of increase in hospital costs, the average increase in the expense per admission was calculated for all hospitals in each state and the District of Columbia for each year from 1970 to 1978.

Calculation of increases in total hospital expenses requires a technique to measure a hospital's output of both inpatient and outpatient services. Admissions are a natural unit for inpatient treatment, whereas patient visits are the natural unit for outpatient services. In order to obtain an aggregate volume of services, it is common to calculate "equivalent inpatient" services by converting outpatient visits into a fraction of inpatient services. The fraction used is the ratio of the average revenue per outpatient visit to the average revenue per inpatient unit measured. This approach, which the AHA employs to compute adjusted patient days,[8] was used in this study to compute the number of equivalent admissions.

We then obtained the expense per equivalent admission (EPEA) by dividing the total expenses by the number of equivalent admissions. The number of equivalent admissions is the sum of the number of inpatient admissions plus the product of the number of outpatient visits times the ratio of revenue per outpatient visit to revenue per inpatient admission:

$$\text{equivalent admissions} = \left(\text{outpatient visits} \times \frac{\frac{\text{outpatient gross revenue}}{\text{outpatient visits}}}{\frac{\text{inpatient gross revenue}}{\text{admissions}}} \right) + \text{inpatient admissions}$$

The expense per equivalent admission was then calculated as the total expenses divided by the number of equivalent admissions.

The EPEA was thus calculated each year from 1969 to 1978 for each of the 50 states and the District of Columbia. The EPEA was also calculated for the six rate-setting states as a group and for the 44 non-rate-setting states and the District of Columbia as a group. The rates of the increase from year to year, expressed as a percentage of the previous year, were then calculated; the mean rates of increase in EPEA for the rate-setting states were compared with the mean rates of increase in the non-rate-setting states and the District of Columbia (Fig. 1). In addition, the rates of increase in EPEA for each of the six rate-setting states were compared with the mean performance of the non-rate-setting states and the District of Columbia (Fig. 2).

Because both the sample sizes and the variances were significantly different, the Behrens–Fisher statistic[9] was used to compare

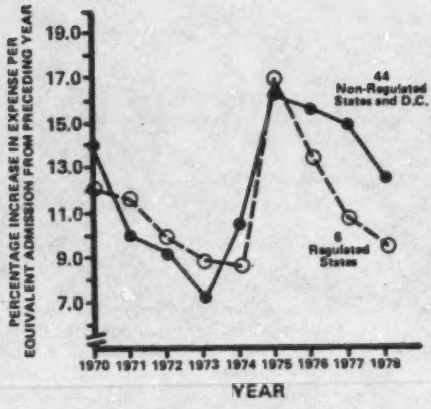

Figure 1. Annual Percentage Increases in Expense per Equivalent Admission (EPEA) of Rate-Setting and Non-Rate-Setting States, 1970-1978.

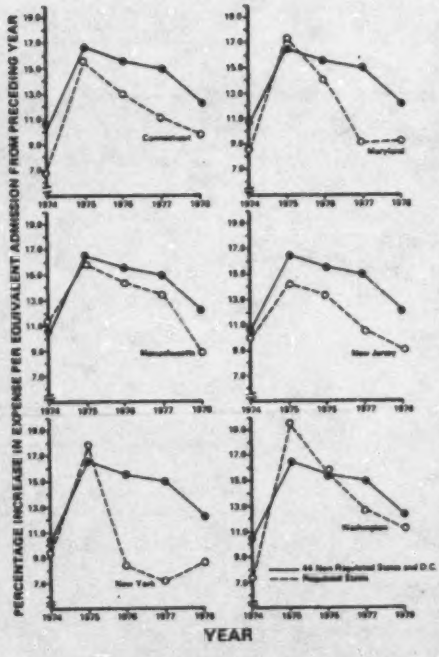

Figure 2. Annual Percentage Increases in Expense per Equivalent Admission (EPEA) for Each Rate-Setting State Compared with Increases in EPEA for Non-Rate-Setting States, 1974-1978.

the mean rates of increase in EPEA of the rate-setting states with those of the non-rate-setting states and the District of Columbia.

Results

Figure 1 compares the rates of increase in EPEA for the rate-setting and non-rate-setting states from 1970 to 1978. The annual rates of increase in EPEA show no discernible pattern of difference between rate-setting and non-rate-setting states until 1976, when they begin to diverge. The Behrens–Fisher test shows that the differences in EPEA between the rate-setting and non-rate-setting states were significant in 1976 ($P<0.05$, degrees of freedom = 5,44) and highly significant in 1977 and 1978 ($P<0.005$, degrees of freedom = 5,44.).

Figure 2 compares the rate of increase in EPEA from 1974 to 1978 for the non-rate-setting states with that of each rate-setting state. The individual graphs show that of the six rate-setting states only Washington had a rate of increase above the national average in 1976, and that in 1978 all six rate-setting states had smaller increases in EPEA.

Discussion

Although comprehensive, legally mandated rate-setting programs have been in effect for as long as eight years, it is only in the past three years that notable differences between rates of cost inflation in rate-setting and non-rate-setting states have emerged.

One explanation for the difference between the findings reported here and those reported in earlier studies is that because the state programs were only established between 1970 and 1975, earlier reporting periods did not allow them adequate time to become effective. There are indications that state programs and officials refine their administrative procedures and gain political skill in the early years of operation.[10,11] For example, although the Maryland Health Services Cost Review Commission was established on July 1, 1971, and given regulatory authority on July 1, 1974, only one hospital had been fully reviewed by July 1, 1975. It was not until July 1, 1977, that the rates of all Maryland hospitals had been approved by the commission.

A second explanation for the recent trend is that only in the past few years has the concern with high rates of increase in hospital costs become a sufficiently visible public problem to give the officials of state programs the incentive (and perhaps the political support) to reduce the rate of cost increase. The high rate of increase nationwide during the early part of this period — 16.9 per cent in 1975 and 13.7 per cent in 1976 — may have increased the commitment of both the public and the state employees to improvement of the programs. In addition, the introduction of the Carter administration's hospital-cost-containment proposal in early 1977 and the subsequent consideration of that proposal by Congress may have increased the states' interest and the regulators' ability to restrain cost increases.

Finally, it must be noted that the Nixon administration's Economic Stabilization Program operated from August 1971 to April 1974 and included specific rules to limit cost increases in hospitals nationwide. By reducing the rate of increase in hospital costs in non-rate-setting states, the Economic Stabilization Program may have masked any effect of state programs during this period.

With the recent Congressional rejection of the federal cost-containment bill, state initiatives to control hospital cost increases have taken on added importance. The data reported in this paper reveal a statistically significant reduction in average annual cost increases in rate-setting states as compared with non-rate-setting states from 1976 to 1978. These data are consistent with the view that mandatory rate-setting programs that establish rates prospectively and cover most patients can effectively contain increases in hospital costs.

Further analysis of the effects of state rate setting is of course necessary. The precise effects of rate setting on per capita use, the intensiveness of hospital services, the salaries of hospital employees, the prices paid by hospitals for goods and services, and a wide variety of other factors are all matters of interest. Ultimately, information on the relation between differences in per capita hospital expenditures and the health status of population groups will be desirable. Such analysis, when available, will permit the development of even more sophisticated hospital payment policies. Meanwhile, we believe that the results of this analysis support a more optimistic view of the effectiveness of state hospital rate-setting programs than that of the studies that covered earlier reporting periods.

We are indebted to Mr. Steven Renn and Dr. Susan Horn for assistance with the computer and statistical analyses, and to Ms. Janet Archer for her comments on the manuscript.

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APPENDIX 2

Rates of Increase in Expense per Equivalent Hospital Admission in States with and without Cost Regulation, 1970-1979.

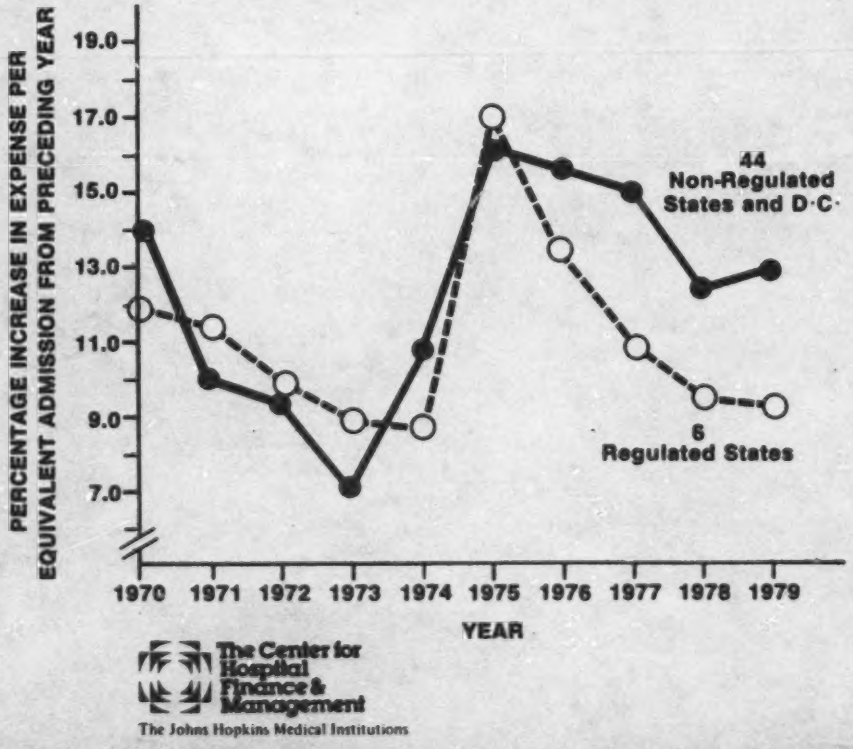
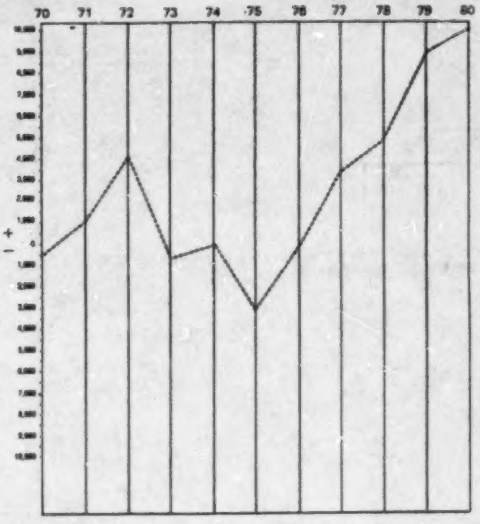


TABLE 5

TRENDS IN MARYLAND HOSPITAL FINANCIAL STATUS

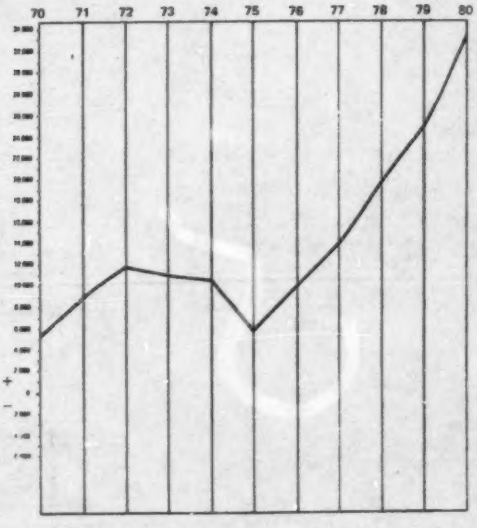
	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	ANNUAL PERCENT GROWTH
BALANCE SHEET												
1 AVERAGE AVAILABLE BEDS	10499	10738	11018	11024	11214	11381	11737	11856	12283	12578	12613	1.85
2 CURRENT RATIO	1.61	1.60	1.77	1.77	1.64	1.62	1.54	1.56	1.51	1.50	1.62	0.06
3 CUR ASSETS/TOTAL ASSETS	0.20	0.21	0.22	0.21	0.22	0.23	0.23	0.23	0.22	0.22	0.23	1.41
4 UNREST FUND BAL/ASSETS	0.67	0.67	0.64	0.63	0.62	0.60	0.55	0.52	0.48	0.44	0.43	-4.34
5 TOT FUND BAL/TOTAL ASSETS	0.70	0.68	0.68	0.65	0.64	0.61	0.57	0.54	0.49	0.47	0.44	-4.54
6 LONG TERM DEBT/GROSS PPE	0.21	0.21	0.21	0.26	0.25	0.26	0.31	0.34	0.39	0.40	0.48	8.62
7 LONG TERM DEBT/NET PPE	0.29	0.28	0.30	0.37	0.36	0.38	0.46	0.50	0.57	0.59	0.70	9.60
8 UNRESTRICTED ASSETS/BED	39.17	42.12	43.87	49.02	50.81	55.45	61.39	68.32	77.54	85.03	97.19	9.51
9 TOTAL ASSETS/BED	45.56	46.79	48.47	53.41	55.94	60.98	68.26	74.98	84.94	89.63	100.33	8.21
10 LT DEBT/TOTAL FUND BAL	0.24	0.25	0.26	0.34	0.34	0.37	0.45	0.54	0.68	0.75	0.92	14.38
11 GROSS PPE/BED	36.19	38.65	40.38	44.71	48.07	54.17	57.34	64.07	72.05	78.49	85.92	9.03
12 FUND BALANCE/BED	26.39	28.23	28.97	30.85	31.75	33.39	33.96	35.84	36.90	39.46	41.71	4.68
INCOME STATEMENT												
13 OPER EXP TO OPER REVENUE	1.00	1.00	0.99	1.00	1.00	1.01	1.00	1.00	0.99	0.99	0.99	-0.10
14 OPER EXP TO TOTAL REVENUE	0.98	0.98	0.97	0.98	0.98	0.99	0.99	0.98	0.98	0.98	0.97	-0.10
15 OPERATING MARGIN	-0.17	0.30	1.00	-0.15	0.01	-0.50	0.04	0.44	0.51	0.89	0.86	
16 TOTAL MARGIN	1.84	2.43	2.95	2.38	2.05	0.90	1.29	1.73	2.18	2.43	2.83	4.40
COMBINED												
17 OPERATING REVENUE/ASSETS	0.70	0.77	0.84	0.81	0.87	0.96	0.99	0.99	0.95	0.96	0.95	3.10
18 TOTAL REVENUE/ASSETS	0.71	0.78	0.86	0.84	0.89	0.97	1.01	1.00	0.96	0.98	0.97	3.17
19 OPERATING REV/NET PPE	1.01	1.13	1.28	1.27	1.33	1.43	1.58	1.55	1.47	1.52	1.59	4.64
20 TOTAL REVENUE/NET PPE	1.03	1.16	1.30	1.30	1.36	1.45	1.60	1.57	1.50	1.54	1.62	4.69
21 OPER REV/LONG TERM DEBT	3.61	4.01	4.25	3.41	3.71	3.82	3.45	3.09	2.59	2.57	2.26	-4.58
22 TOTAL REV/LONG TERM DEBT	3.69	4.10	4.34	3.49	3.78	3.88	3.49	3.13	2.63	2.61	2.30	-4.62
23 WORK CAP/DAILY OPER REV	39.72	37.31	41.64	41.07	35.54	32.76	30.16	30.46	28.69	29.45	32.88	-1.87
24 CUR ASSETS/DAILY OPER REV	104.95	99.04	95.42	94.49	91.00	85.95	85.85	85.10	84.66	85.13	86.30	-1.94
25 CUR ASSETS/DAILY TOT REV	92.87	96.98	93.60	92.17	89.18	84.77	84.70	84.02	83.27	83.85	84.62	-1.93
26 CUR LIAB/DAILY OPER EXPEN	60.25	64.72	56.69	55.73	57.83	54.98	57.78	56.89	58.44	59.48	55.98	-1.96
27 OPER REVENUE/FUND BALANCE	1.04	1.15	1.27	1.29	1.40	1.59	1.80	1.88	1.99	2.07	2.22	7.88
28 TOT REVENUE/FUND BALANCE	1.06	1.17	1.30	1.33	1.42	1.62	1.82	1.90	2.02	2.10	2.26	7.86
29 EXCESS OF REV/FUND BAL	0.02	0.03	0.04	0.03	0.03	0.01	0.03	0.03	0.04	0.05	0.06	11.61
30 COMPOSITE AGE OF PLANT	7.22	7.27	7.04	7.74	8.20	8.55	8.52	8.78	8.18	7.95	8.09	1.14

OPERATING PROFIT/LOSS
($000'S)



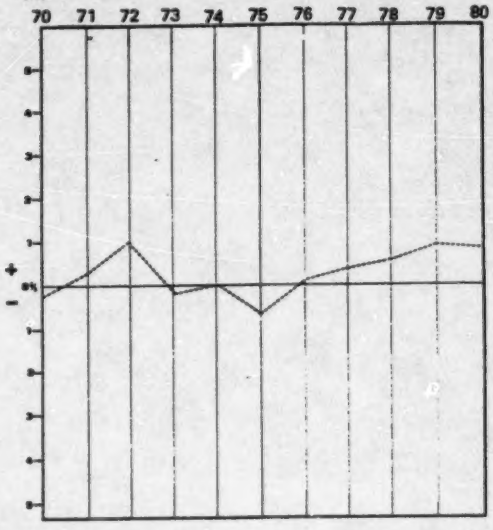
Operating Profit/Loss = Total Operating Revenues Minus Total Operating Expenses

NET PROFIT/LOSS
($000'S)



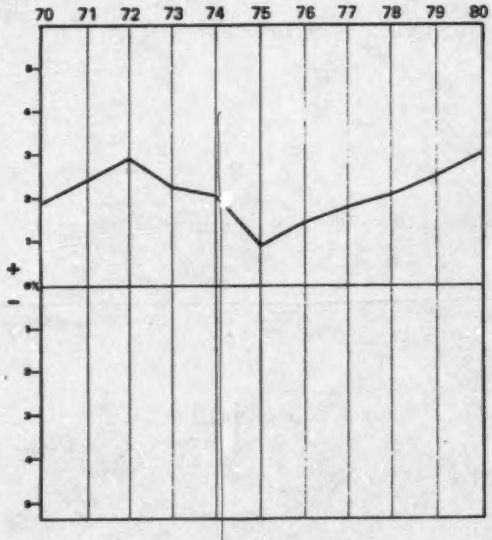
Net Profit/Loss = Total Operating Plus Net Non-Operating Revenue Minus Total Operating Expenses

OPERATING MARGIN
(%)



Operating Margin = Net Revenue From Operations ÷ Total Operating Revenue

TOTAL MARGIN
(%)

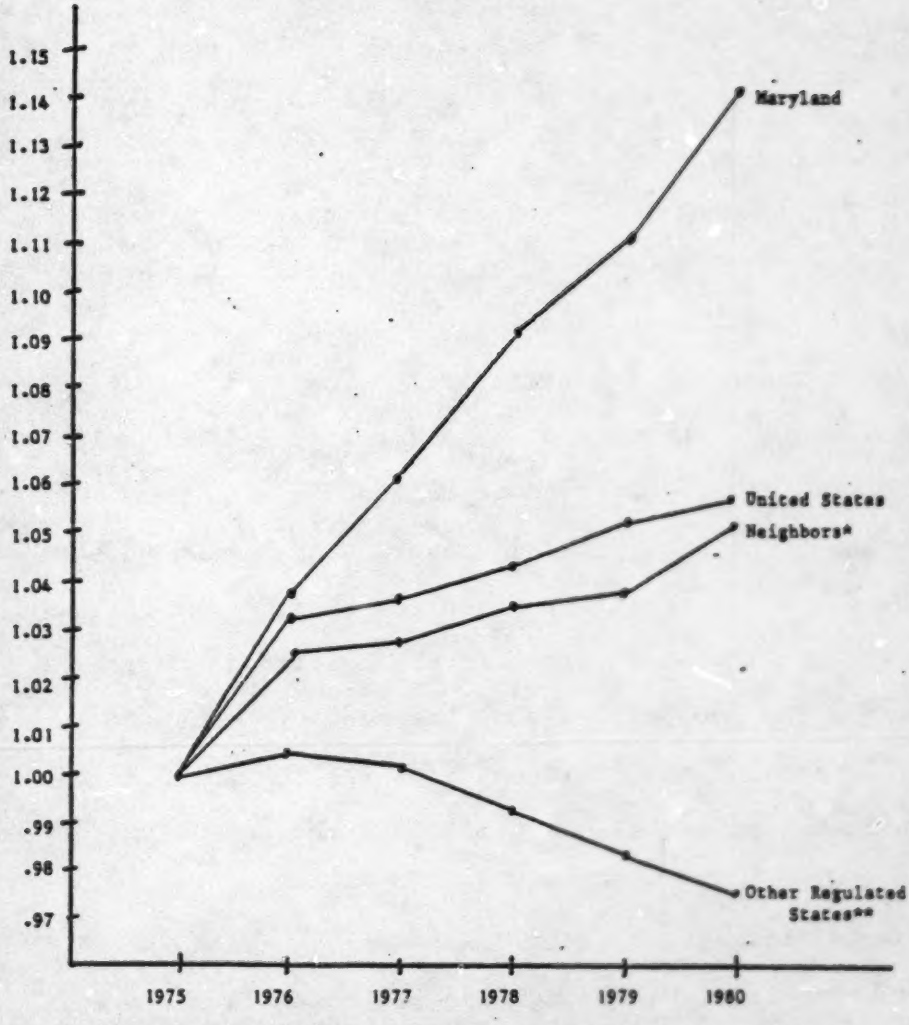


Total Margin = Net Revenue From Operations Plus Net Non Operating Revenue ÷ Total Operating Revenue

APPENDIX 4

TABLE 3

TRENDS IN INDEX
OF TOTAL BEDS FOR COMMUNITY
HOSPITAL, 1975 - 1980



SOURCE: American Hospital Association, Hospital Statistics, 1976 - 1981

* Delaware, West Virginia, Pennsylvania, Virginia, New Jersey, District of Columbia

** Connecticut, Washington, Massachusetts, New York, New Jersey

QUESTION: UNDER THE MARYLAND PROGRAM, ARE HOSPITALS AT RISK FOR LOSSES IF THEIR COSTS EXCEED THE PROSPECTIVELY SET PAYMENT AND CAPABLE OF PROFITING IF COSTS ARE LESS THAN PAYMENT? IF SO, ARE HOSPITALS GENERALLY PROFITING OR INCURRING LOSSES FROM THIS PROGRAM?

ANSWER: Under the Maryland Guaranteed Inpatient Revenue (GIR) system, which is the reimbursement mechanism for most of the states' hospitals, there are strong financial incentives for a hospital to carefully monitor its expenditures. If a hospital expends less than its agency-approved guaranteed revenue per admission, the hospital is rewarded by having those savings added to its approved revenues in the following year. By the same token, if the hospital's costs exceed the prospectively set payment, the hospital, while not actually being at risk for the loss in the current year, will be penalized in the following year by having the excess subtracted from its following year's approved revenues. Because a hospital's revenues in a succeeding year are based on the prior year's revenues, and not on the prior year's costs, the hospital suffers no penalty for controlling its expenditures, and can accrue the benefits of its savings in subsequent years. Combined financial statements indicate that Maryland hospitals had a net

profit of over $33 million in 1980, and that both the operating margin and total margin have increased steadily since 1975. The hospitals' excess of revenue over expense has, since 1970, increased at an annual rate of 20.1 percent, and at a rate of 43.5 percent since 1975.

QUESTION: YOUR STATEMENT NOTES THE SUCCESS OF SIX MANDATORY PROGRAMS. DO YOU BELIEVE THAT VOLUNTARY PROGRAMS CAN HAVE THE SAME PROBABILITY FOR SUCCESS?

ANSWER: The data we have accumulated indicate that the past attempts at voluntary solutions have met with little success. Certainly the formal Voluntary Effort of the A.H.A. failed and was abandoned by the Association. Voluntary programs in Arizona, Minnesota, and Pennsylvania have shown only modest to weak promise in reducing cost inflation. Smaller scale voluntary efforts, based in specific communities, may hold more potential hope. However, like the Voluntary Effort, one can expect less impressive results simply because there are no incentives for compliance, and no sanctions for non-compliance. Additionally, voluntary programs can only be effective so long as participants and sponsors feel that their financial interests are not threatened or that by cooperating they can avoid

what would be perceived as a worse evil. Without the threat of a major change in reimbursement mechanisms, it is unrealistic to expect voluntary programs to be successful in the future.

QUESTION: OPPONENTS OF THE MARYLAND PROGRAMS SAY THAT OVER THE PERIOD 1976-1980, BOTH TOTAL MEDICARE SPENDING PER ENROLLEE AND IN-PATIENT SPENDING ROSE FASTER IN MARYLAND THAN IN THE REST OF THE U.S. THEY ARGUE THAT COST PER ENROLLEE IS THE TRUE TEST BECAUSE IT CONSIDERS CHANGES IN THE NUMBER OF ADMISSIONS AS WELL AS ADMISSION COSTS. HOW WOULD YOU RESPOND TO THIS?

ANSWER: The FAH study which presented these data has several serious drawbacks. First, examining the time period from 1976 to 1980 is improper, since the Maryland waiver did not become effective until July 1, 1977. A simple correction of their choice of time periods yields data indicating that both total Medicare spending per enrollee and inpatient spending rose faster in the rest of the United States than in Maryland. Second, the figures used for Medicare expenditures were not actual benefits paid, but instead were estimates based on interim reimbursements. Likewise, the number of Medicare enrollees is not a

substitute for the number of Medicare admissions. The best index to examine, in making a comparison similar to that attempted by the FAH, would be the ratio of Medicare inpatient hospital benefits paid to the number of Medicare hospital admissions in a state. Finally, aside from the above criticisms, it should be remembered that under the Maryland waiver, Medicare agreed to pay Maryland hospitals at rates equal to 94 percent of those paid by other payors, instead of the customary 75 to 80 percent, in hopes of obtaining long-term cost containment at the risk of a possible short-term loss.

Senator DURENBERGER. Thank you very much.

Before we go to Mr. Crane, I am informed that both Dr. Block and Dr. Vasile have somewhat of a time problem in getting back to Rochester.

And, unless you have a time problem, Mr. Crane, in getting to Albany, I would like to ask Dr. Block to go next and then ask Dr. Vasile to come up and follow him so that we can get their presentations.

Is that all right with you?

Mr. CRANE. That's fine.

Senator DURENBERGER. All right.

STATEMENT OF DR. JAMES A. BLOCK, PRESIDENT, ROCHESTER AREA HOSPITALS CORP., ROCHESTER, N.Y.

Dr. BLOCK. Senator, I am very pleased to have the opportunity to speak to you on behalf of the Rochester community and the Rochester Area Hospitals Corp.

I think it is important to stress that it is in fact because of the wisdom of this committee and your decision to pass in 1972 the 222 provisions that permitted medicare waivers that we are able to speak to you today about our experience in Rochester.

I also would like to add, with some humor, that Rochester is not a State. We are a metropolitan area. We in fact are not a government. We are a voluntary corporation, the Rochester Area Hospitals Corp., and it is because of the voluntary nature of our program that I believe we were invited here today.

It is a most unusual situation and a most unusual corporation. I believe that there is none quite like it in the United States, and that is only to suggest that we think there are some lessons to be learned from this voluntary effort in Rochester.

Perhaps I should underscore the point that in the first 2 years of the reimbursement experiment in Rochester, N.Y., we believe that we have recorded the lowest rate of increase in hospital expenses in the Nation 2 years in a row. In 1980 our experience was a 9.1-percent increase; in 1981, a 10-percent increase. These figures, of course, are approximately half of the national average. And to put it in a slightly different context, had the hospitals in the rest of the Nation performed at the same level the national savings would have been in the range of $10 to $15 billion.

Now, it is important to stress that the Rochester program is more than a reimbursement experiment. It is more than an experiment in prospective payments. It has all of the attributes of prospective payment systems that have been alluded to this afternoon, and those attributes are extremely important. That is to say, our hospitals are able to benefit from cost reductions; if their expenses are less than their predictable revenue, they keep the entire savings.

Second, it is important to stress that our hospitals live in a predictable environment. To the extent that their revenue is predictable, management is in a position to manage. They are no longer in a position to blame Albany or to blame Washington for their problems.

It was also stressed that prospective reimbursement systems are product oriented. And I think that that is an extremely important attribute. To me, one of the great weaknesses in our existing reimbursement is not only the fact that it is cost-based but the fact that it has not brought clearly into focus the importance of the product of the hospital industry. In my mind, as a physician, the product of the industry is clinical medicine. To the extent that we understand that product, we not only understand the cost of producing it but the quality of the product.

So a very important result of our reimbursement system in Rochester we are now focusing on—the resources required to produce the product and the quality of the product—which has resulted in physicians becoming a very active participant in the management system of hospitals and are beginning to understand the nature of what we are providing to our citizens.

Another interesting attribute of this reimbursement system is that it is global in nature; that is to say, it encompasses all of the hospitals in the entire metropolitan area and that they have agreed to a single revenue cap. As a result, there are powerful incentives for sharing in services; there are powerful incentives to support the planning system.

In addition to an overall revenue cap related to operating expenses, there is also included in that revenue cap a cap on additional operating expenses that could be added to the system as a result of new certificate-of-need projects. This is extremely important.

First, it means that the hospitals together are the first step in the certificate-of-need process in Rochester. They review each other's certificate-of-need applications, and when a certificate-of-need application is recommended for approval we also recommend the level of increase in expenditures that are added to the system, but we do that within the overall revenue cap. So we have not only capped historical expenses and their rate of increase but we also

have a cap on the level of increase that is permitted to be added to the system each year as the result of new projects, and that amount of money is shared among the hospitals as a group. This results in very profound cooperation in the planning environment.

What we have, then, is a voluntary system. The hospitals have voluntarily joined this corporation. They have together designed this new reimbursement system. But it is an interesting voluntary system in that it is in partnership with government. We could not have done this without the support of New York State, without the leadership of the Office of Health Systems Management of the New York State government; nor could we have done it without the support and cooperation of the Federal Government through HCFA. Together they have given us the authority to design and manage our own reimbursement system.

I would like to end by stressing that the reimbursement experiment is in reality an experiment in management, that one should not view prospective reimbursement systems as simply changing the flow of dollars to hospitals. More importantly, these reimbursement systems create the opportunity for entirely new approaches to the management of the hospital industry and to cooperative efforts among hospitals.

I would stress that, whatever is done, it should continue to encourage prospective reimbursement; it should as much as possible encourage volunteerism and the opportunity for local initiatives as has been demonstrated in Rochester; and it should continue to emphasize the importance of the product of the hospital industry, and that is clinical medicine.

It is interesting to bring to your attention that perhaps the most significant article that has been written on the product of the hospital industry was written in 1913. It was written by a doctor who, at that time, was the medical director of Massachusetts General Hospital. His name was Dr. Codman. His paper was entitled "The Clinical Product of the Hospital," and it was delivered to the Philadelphia Medical Society in 1913.

At that time he suggested to his colleagues that in order for hospitals to be effectively managed, in order for costs to be contained, and in order for quality to be assured and maintained, we needed to understand the product of what we were delivering and that the reimbursement system should reinforce that product.

His ideas were not accepted at that time. The concept that management should be based on the clinical product was viewed as threatening by many, and unfortunately he lost his position. I think perhaps the time has come to reevaluate his ideas, to reinforce those ideas with new incentives in reimbursement systems, and to join those efforts with overall efforts in hospital planning.

Thank you very much.

Senator DURENBERGER. Thank you very much.

Now we will go to Dr. Vasile.

Dr. BLOCK. All right

[The prepared statement of Dr. James A. Block and answers to questions from Senator Durenberger follow:]

RA
HC

Rochester Area
Hospitals' Corporation
220 Alexander Street, Suite 808
Rochester, New York 14607 716-546-3280

James A. Block, M.D.
President

June 21, 1982

Senator David Durenberger
Chairman, Senate Subcommittee on Health
Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Durenberger:

I am honored to have the opportunity to testify before the Committee on Finance, Subcommittee on Health regarding perspective payment systems for hospitals. I am submitting, as my written testimony, the 1981 Annual Report of the Rochester Area Hospitals' Corporation. We believe that our Hospitals Experimental Payments Program (HEP), which has held hospital expense increases during 1980 and 1981 to approximately 10% per year, slightly over one-half the rate of national hospital expense increases, represents the lowest community-wide hospital expense increase in the nation during the past two years. More importantly, however, this experiment represents a cooperative effort on the part of the Rochester hospitals who have joined in a voluntary alliance to assure the highest quality medical care in the most cost effective manner.

I look forward to sharing my thoughts with your Committee.

Sincerely,

James A. Block M.D.

James A. Block, M.D.
President

JAB/k
Att.

1 Executive Summary

For the second year in a row, the 10% increase in costs at hospitals in the Rochester, N.Y. area was just over *half* the 18.7% rate of increase experienced nationally. Elsewhere in New York State, where hospitals are subject to tight rate regulation, hospital cost increases exceeded those in Rochester. Yet the Rochester area's hospitals increased the volume of patient care they provided, enhanced a variety of clinical services, and operated in the black.

How was this accomplished?

The answer lies in a unique five-year demonstration called the Hospitals Experimental Payments (HEP) Program, under which all hospitals in the community are exposed to powerful new financial incentives to improve productivity, freed from the constraints of traditional reimbursement, and allowed to operate responsively under local management initiative.

Under HEP, the nine Rochester area hospitals as a group are guaranteed a predictable income from major insurers of hospital care—Blue Cross, Medicare and Medicaid—over a five year period, with adjustments to reflect the impact of inflation and changes in volume of patient care. Regulations that formerly hampered effective management, such as those which penalized efficient hospitals by reducing income when expenses were reduced, have been eliminated. In return, the hospitals have contracted to provide quality care while living within their community-wide revenue cap. Under the HEP agreement, contingency funds not required by the hospitals will be shared with the payors who advanced these funds.

Experience is demonstrating that the Rochester area hospital system under HEP is operating in the black and

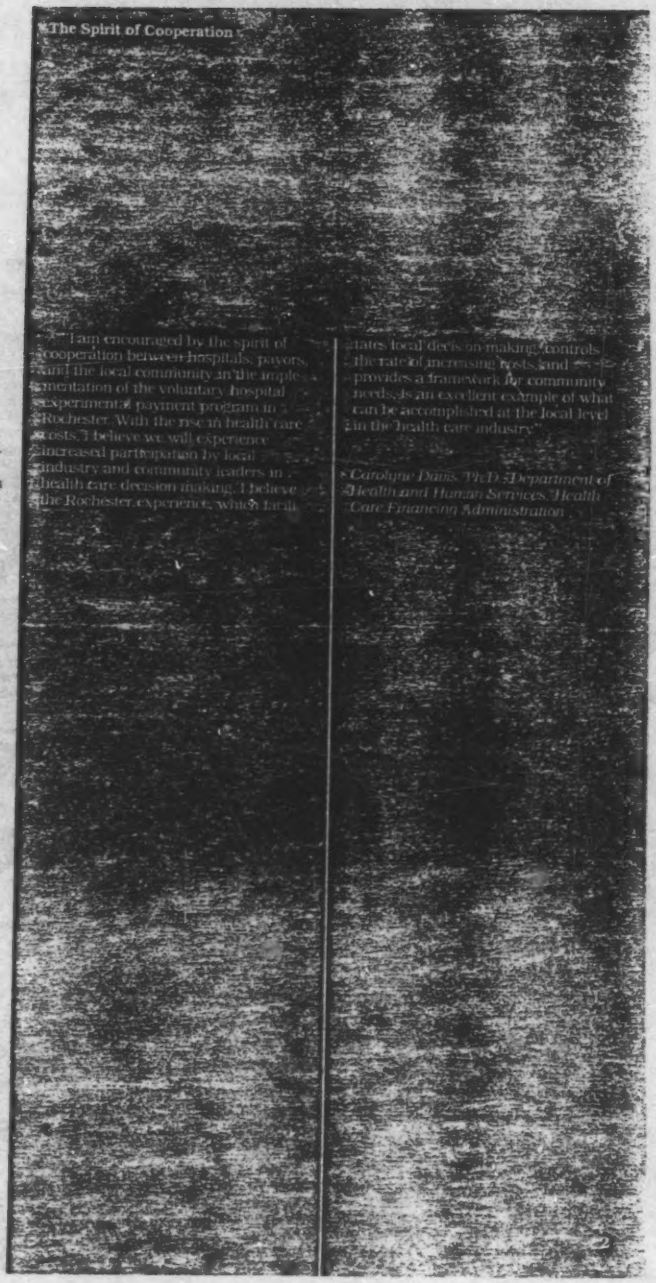
strengthening its financial and clinical capability to meet future needs—while maintaining its reputation for excellence in hospital care and medical education.

With the Reagan administration's emphasis on decentralized, non-regulatory approaches for reforming the inflation-prone health care industry, HEP is already drawing attention nationally as a promising model. Representatives of HEP's parent group, the Rochester Area Hospitals' Corp., have described HEP to the U.S. Senate Finance Committee's Sub-Committee on Health; health publications have noted its promising performance; a growing stream of inquiries and visitors reflects the interest of other localities and states; and continuation of support from The John A. Hartford Foundation of New York City similarly recognizes the potential of the Rochester experiment.

Newfound fiscal stability under HEP is freeing Rochester area hospitals to take a hard look at other tough questions—such as how many acute hospital beds the community needs, and where they should be located. The difficulty of these decisions is compounded by many factors, including:

- ☐ The back-up of long-term care patients in acute beds, a nationwide problem;
- ☐ Continuing rigidity in the long-term care reimbursement system, which hampers effective patient placement;
- ☐ An aging population, with corresponding changes in health care needs;
- ☐ A voter mandate to the federal government coupled with a shaky national economy that is forcing reexamination of all public priorities, including health care.

The process of tackling these difficult issues is providing a focal point for cooperation among leaders in health care, business, industry, government and the community at large, as they join the search for new and workable ways to meet the community's needs for hospital care.


The Spirit of Cooperation
"I am encouraged by the spirit of cooperation between hospitals, payors, and the local community in the implementation of the voluntary hospital experimental payment program in Rochester. With the rise in health care costs, I believe we will experience increased participation by local industry and community leaders in health care decision making. I believe the Rochester experience, which facilitates local decis on making, controls the rate of increasing costs, and provides a framework for community needs, is an excellent example of what can be accomplished at the local level in the health care industry."
Carolyne Davis, PhD, Department of Health and Human Services, Health Care Financing Administration

2

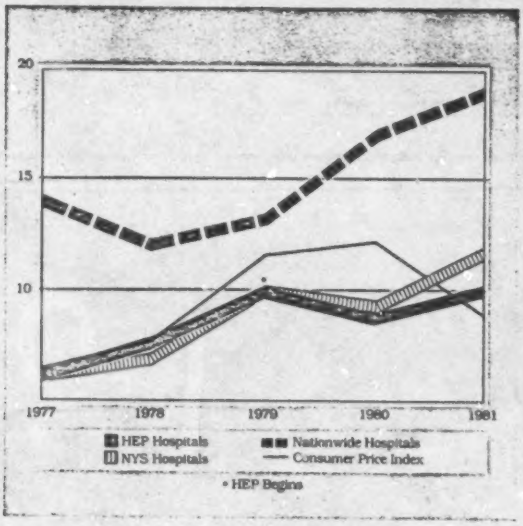
Black Ink on the Bottom Line: HEP's Second Year

During 1981 the nine hospitals participating in the Rochester Area Hospitals Experimental Payments (HEP) Program continued to improve their overall fiscal position. For the second consecutive year they operated within the voluntary community-wide cap on hospital expenditures established under HEP, while at the same time reporting positive operating and net margins.

The hospitals achieved this goal despite increased patient days coupled with declining admissions. This lengthening of hospital stays is believed to be related in part to the backup of long-term patients in acute hospital beds. Since in-patient revenues under HEP are related to numbers of patients admitted rather than to individual services provided or length of stay, hospitals are encouraged to seek the most cost-effective ways to provide necessary health care.

The year's results gave further support to a basic premise of HEP, which is that hospitals and their medical staffs can improve productivity and maintain better control over rising costs when they are assured predictable income and provided opportunities to respond to positive financial and planning incentives.

HOSPITAL EXPENSE TRENDS
Percent increase over previous year



Hospital costs in the Rochester area rose 10%* during 1981, in comparison with a 12% rise in New York State, and 18.7% nationwide. The HEP hospitals' cost increase also compares favorably with the increase in the medical care component of the Consumer Price Index. While the CPI as a whole rose 8.9% in 1981, its medical care component rose 12.5%.

The improvement in the Rochester area hospitals' overall financial status is reflected by indicators of liquidity and cash position. Cash flow has been eased greatly by the prospective payment process under HEP, which has helped to reduce average collection periods for receivables to 34.6 days. This compares with an industry average of almost 60 days.

Although the 1981 net operating margin of .011 for the hospitals as a group remains below industry averages, this indictor shows significant improvement over its level prior to HEP. During the mid-1970s, Rochester area hospitals, like others in New York State, were under increasing fiscal pressure. As a group, RAHC hospitals showed operating losses in two of the three years preceding the start of HEP in 1980. Operating deficits were, and remain, a Statewide problem: one study** shows that nine of every 10 voluntary hospitals in the State operated in the red for at least two of the five years from 1974 to

*The rate of increase for HEP hospitals in 1981 would be 10.7% if adjustments were made for certain changes in physician billing practices that would lower the 1980 cost base used for comparison. The unadjusted basis is used here because it is more directly comparable to State and National statistics.

**Schwartz, W.B., M.D.: "The Regulation Strategy for Controlling Hospital Costs," *New England Journal of Medicine* 1981; 305:1249-1255 (Nov. 19, 1981).

1978. One-fourth of the $2 billion equity of community hospitals Statewide had to be used to underwrite operating losses during the study period.

By helping to stem this erosion of equity, HEP supports the community's efforts to preserve a quality hospital system. Continuing progress toward fiscal stability will allow Rochester area hospitals to maintain and replace physical plants and equipment to meet growing or changing health care needs, and to remain competitive in the marketplace for top-caliber professional and support staff.

Service Improvements

With predictable revenues under HEP, the hospital system has expanded and improved a variety of clinical services during 1981. In doing so the hospitals have cooperated closely with State and local planning authorities in efforts to yield more rapid approval and implementation of needed new services and technologies.

In the area of cardiovascular diseases, for example, clinicians defined a need for an increase in the community's treatment capacity. Implementation of the recommended expansion had begun in 1980. During 1981 RAHC approved HEP funding for several proposals including expanded open heart surgical capacity at Strong Memorial Hospital and Rochester General Hospital, an outpatient rehabilitation program for cardiac patients at St. Mary's Hospital, and new cardiac monitoring equipment at The Genesee Hospital. During review of its application, Genesee agreed to share its evaluation of this new equipment with the RAHC Medical Advisory Committee, so that patients and physicians at other hospitals could benefit from its experience.

Hospital services and support staff were also strengthened in other ways during 1981, including expansion of the community's ambulatory surgery capacity and implementation of a variety of other programs and services. Since all hospital care must be provided within the community cap on revenues established under HEP, cost impact is an important consideration in planning for any additional services. In some cases hospitals have found that services designed to improve care can also reduce costs. One illustration is a nutrition support service initiated at Strong Memorial Hospital during 1981 to improve nutrition of patients requiring intravenous or tube feeding. This service has improved patient care, decreased costs of formula preparation and feeding equipment, and identified more patients who could be tube-fed as a substitute for the more costly intravenous feeding. A study is now being conducted to determine the relationship between improved nutrition and length of hospitalization.

Funding for Changing Needs

The Contingency Fund set aside each year under the HEP program is used in part to help hospitals adjust to changes in patient volume occurring as the year progresses.

The Contingency Fund also provides operating revenues for approved Certificate of Need projects. During 1981 these included the cardiac surgery expansions at Strong Memorial and Rochester General Hospitals; and establishment of an out-patient mental health facility at Noyes Memorial Hospital in Livingston County. The Noyes mental health project will draw psychiatric staff from The Genesee Hospital in Rochester, thereby extending a specialized service into a predominantly rural area.

Another major purpose of the Contingency Fund is to support special projects that are consistent with the goals of HEP. For example, during 1981 several hospitals received funding for Geriatric Assessment Teams aimed at

Hospital Utilization

	1981*	1980	1979	1978
Admissions	99,492	104,263	107,013	105,384
Patient days	845,704	835,692	841,697	837,356
Emergency dept. visits	197,201	208,048	207,931	206,631
Clinic visits	338,903	336,788	316,320	300,989

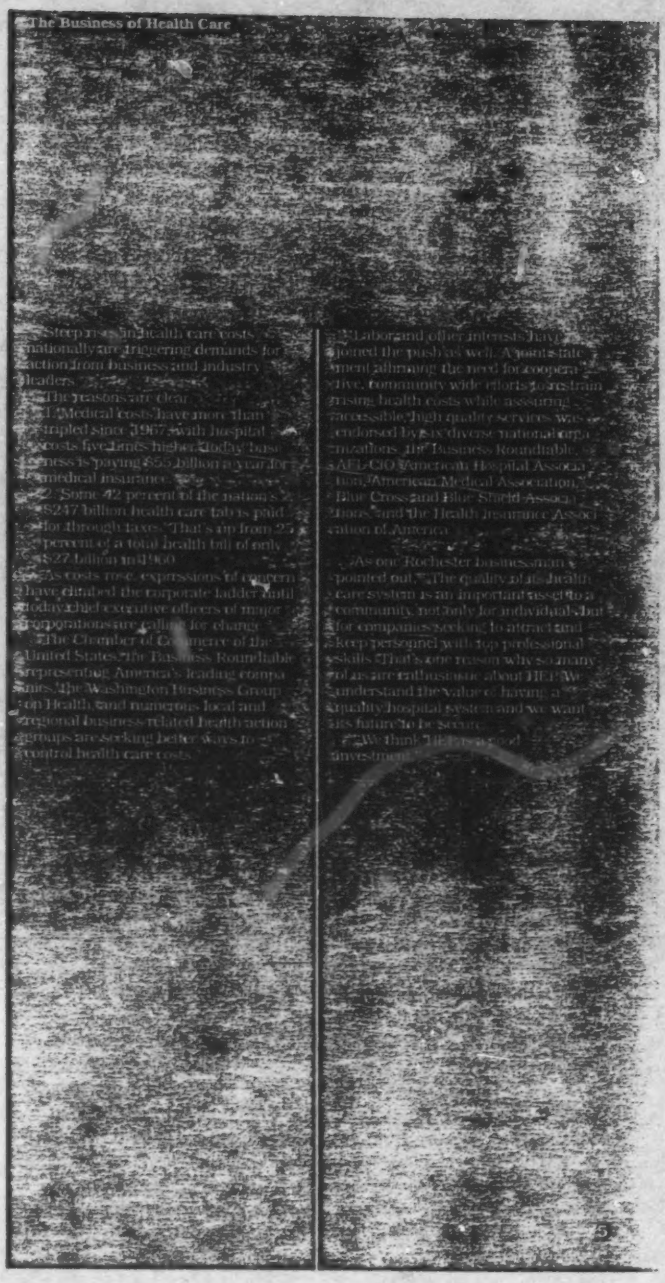
Hospital Financial Indicators

	HEP Hospitals			Industry average
	1981*	1980	1979	
Current Ratio *Current assets ÷ current liabilities*	2.33	1.53	1.36	1.86
Average Collection Period *Net days in A/R*	34.6	40.5	52.5	59.2
Net Operating Margin *Net operating income ÷ operating revenue*	.011	.012	(.01)	.022

**These data are preliminary and include estimates based on hospitals' submissions to RAHC.*

improved management of patients who need both acute and chronic care. Another group of special projects receiving Contingency Fund support during 1981 will help hospitals to integrate HEP incentives into their management structures and learn to use new information that is becoming available through the community-wide data base. The integrated clinical and financial formats yield data on the interrelationship between clinical decisions and hospitals' resource allocations. Analysis of this information will enable better understanding of the effectiveness of patient care.

As HEP enters its third year, Rochester area hospitals continue to benefit from a stable revenue base that provides a rational environment for long-term planning and exploration of options for community service.



All HEP Hospitals
Combined Financial Statements

For the Calendar Years 1978 to 1981*
Amounts in thousands

Statement of Changes in Cash Position

	1981	1980	1979	1978
Cash from Operations:				
Operating Surplus (Deficit)	$ 3,578	$ 3,339	$ (1,307)	$ 656
Charges to Operations not requiring a Cash Outlay (principally depreciation expense)	14,968	14,081	13,497	12,755
Total Cash from Operations	$ 18,546	$ 17,420	$ 12,190	$ 13,411
Other Sources/(Uses):				
Non-Operating Revenue (principally interest income)	$ 7,316	$ 4,677	$ 1,784	$ 1,713
Decrease/(Increase) in Net Current Assets, excluding Cash	(11,630)	3,178	5,850	(2,464)
Other	13,351	337	(691)	2,984
Total Cash Provided	$ 27,583	$ 25,612	$ 19,133	$ 15,644
Cash used for Capital Expenditures:				
Additions to Property, Plant & Equipment	$ 17,077	$ 12,154	$ 8,133	$ 9,549
Decrease/(Increase) in Long-Term Debt	3,262	3,440	2,453	3,124
Total Applications for Capital Purposes	$ 20,339	$ 15,594	$ 10,586	$ 12,673
Net Increase/(Decrease) in Cash	$ 7,244	$ 10,018	$ 8,547	$ 2,971

*For purposes of comparison, Monroe Community Hospital, which began to participate in HEP in 1981, is not included in these tables.

Balance sheets

	1981	1980	1979	1978
ASSETS				
Cash and Securities	$ 37,494	$ 30,250	$ 20,230	$ 11,883
Other Current Assets (principally accounts receivable)	37,697	38,590	44,566	49,766
Other Assets	11,241	9,259	7,771	5,549
Fixed Assets	206,193	204,156	206,111	211,688
Total Assets	$292,625	$282,255	$278,678	$278,886
LIABILITIES AND FUND BALANCES				
Current Liabilities	$ 32,283	$ 44,806	$ 47,604	$ 48,954
Long Term Debt and Non-Current Liabilities	134,444	137,027	139,317	138,991
Total Liabilities	$166,727	$181,833	$186,921	$186,945
Fund Balance	125,898	100,422	91,757	91,741
Total Liabilities and Fund Balance	$292,625	$282,255	$278,678	$278,686

Statement of Revenue and Expenses

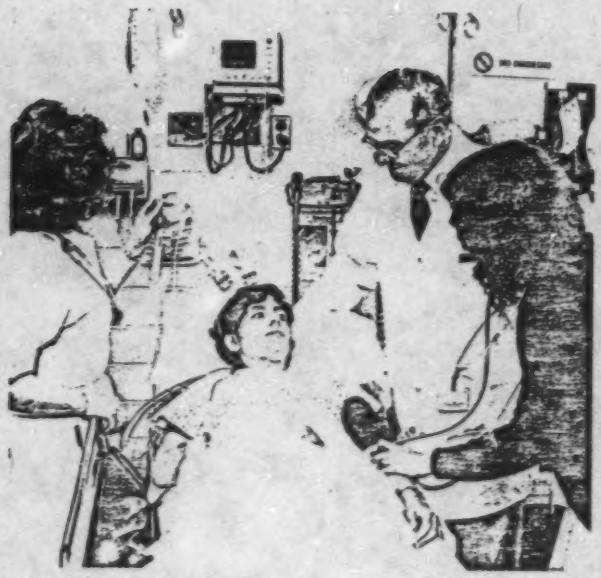
	1981	1980	1979	1978
Net Patient Revenue	$307,045	$278,798	$251,695	$230,574
Other Operating Revenue	9,238	8,651	7,407	6,617
Total Operating Revenue	$316,283	$287,449	$259,102	$237,191
Total Operating Expenses	$312,705	$284,110	$260,409	$236,535
Operating Surplus (Deficit)	3,578	3,339	(1,307)	656
Non-Operating Revenue	7,316	4,677	1,784	1,713
Net Surplus (Deficit)	$ 10,894	$ 8,016	$ 477	$ 2,369

3

Rochester Area Hospitals Tackle the Tough Issues

Fiscal stability under the HEP prospective payment program has relieved Rochester area hospitals of many revenue-related problems. As a result, the hospital system now has new opportunities to tackle difficult basic issues which, if left unresolved, could threaten the community's hopes of maintaining quality hospital care within a health care system it can afford.

One such basic issue concerns acute bed needs—a question which is inextricably interwoven with needs for preventive care and for long-term care. At present, patients often occupy acute beds longer than medically necessary because of various legal and financial barriers to placement at more appropriate levels of care. The severity of the backup problem in the Rochester area is revealed by RAHC data indicating that the number of patients occupying acute beds while awaiting long-term placement has doubled since 1977. By 1981 the monthly average reached 238, about 13% of operated medical-surgical beds in RAHC hospitals.

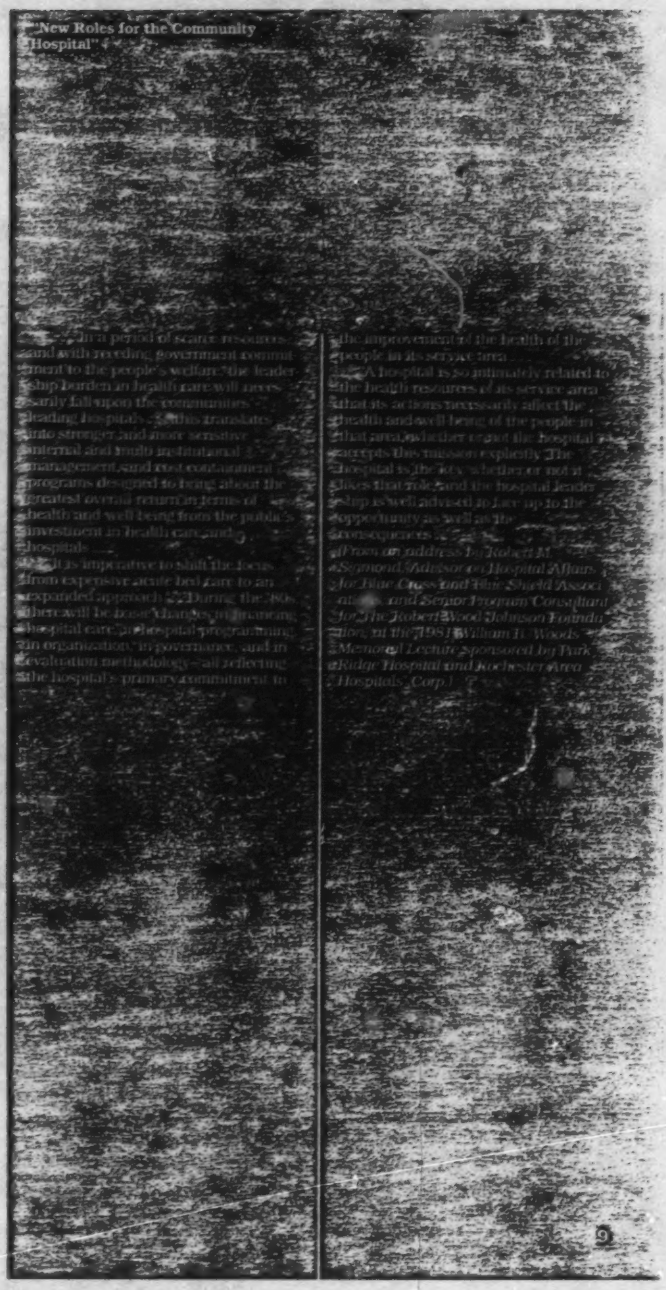


Thus, in spite of improvements in hospital financing under HEP, rigidity affecting other sectors of the health care system continues to hamper hospitals in their efforts to secure effective treatment for those requiring acute care. The result is an apparent "shortage" of acute beds resulting from distortions in the natural market factors affecting the health care system. This condition, although in a sense artificially created, is no less real to those patients and their physicians who need access to hospital beds for acute care.

During 1981 RAHC studied the backup problem in detail. A survey of patients in acute care beds awaiting long-term placement showed that the majority were at least 75 years old and required skilled nursing care. Most had entered the hospital from home via the emergency department. On the average, they had been hospitalized nearly four months. The most difficult cases to place involved Medicaid patients who required high levels of care.

Subsequent analysis led the hospitals to identify several areas for follow-up. These focused on the emergency department as the point of entry for four-fifths of the patients who became "backed-up," along with needs for closer linkages with home care and long-term care providers and better incentives for nursing homes and other providers to serve patients with significant medical disabilities.

As a result, RAHC approved HEP Contingency Fund support for several special hospital-based projects intended to help ease the backup problem. These included development of multi-disciplinary geriatric evaluation teams at all six Rochester and suburban hospitals, a family care program for long-term patients proposed jointly by Rochester General and The Genesee Hospitals, a demonstration SNF level geriatric rehabilitation unit at Strong Memorial Hospital and a unit at Park Ridge Hospital especially oriented to geriatric patients' acute care needs. Contingency


"New Roles for the Community Hospital"

Funds were also approved enabling RAHC, with the cooperation of the Monroe County Long Term Care Program, Inc. (ACCESS) to propose development of a capitation reimbursement system for long-term care.

In the Rochester area, the task of unravelling such perplexing issues is made easier by a strong network of health care planners, providers and payors coupled with a tradition of cooperative action. These assets have made it possible to pursue solutions on several fronts simultaneously. Thus, in addition to its own efforts, RAHC has joined with community agencies and providers including the Finger Lakes Health Systems Agency (FLHSA), ACCESS, voluntary and proprietary nursing home representatives, home health care agencies, and others to develop cooperative solutions to the community's long-term care needs. Rochester's experience with these projects will be evaluated. This research is expected to help advance the level of understanding, which can then be applied to this emerging national issue—how best to provide humane, effective, and affordable care to our chronically ill, elderly population.

Community Planning for Acute Care

Since its inception RAHC has recognized that cooperative planning is necessary to achieve maximum benefit to the community from the resources available for hospital care. During 1981 important progress was made toward development of a Community Hospital Plan aimed at this goal. Four task forces were formed that included more than 80 representatives of all RAHC hospitals and the community at large, plus observers from FLHSA. Organized along clinical lines, the task forces were assembled to explore key issues for hospital services in pediatrics, obstetrics/gynecology, medicine and surgery. Their work was well under way at the end of 1981.

The community's overall need for hospital beds for these services has been defined by the FLHSA based on a State-wide methodology. The first phase of the Community Hospital Plan

includes a review of the State's methodology and preparation of recommendations as to where these beds might best be located. Ultimately these recommendations, when approved by RAHC and its member hospitals, will be submitted to the FLHSA for review and incorporation in their Health Systems Plan which serves as a frame of reference for Certificate of Need applications.

It is indicative of RAHC members' commitment to the planning process that three hospital applications for additional acute beds were voluntarily tabled during 1981, pending completion of the Plan's recommendations in mid-1982.

Although the recommendations of the Community Hospital Plan will be far-reaching indeed, they do not represent an effort to redesign the hospital system. Rather, they are intended to produce a sharper focus on desired future directions for the existing system.

Information: A Vital Resource

Availability of information from the community-wide hospital data base has been a vital advantage for RAHC and its member hospitals in many aspects of their work. As one of the most extensive sources of hospital information in the nation, the data base includes financial data, utilization statistics, and clinical information.

One purpose of the data base has been to facilitate the financial administration of HEP. It is also a cornerstone of the development process for the Community Hospital Plan. One of the most promising applications of the data base, however, lies in its role as the foundation of an information and reporting system that will ultimately provide hospital boards, chief executive officers and medical staffs with reports on the type and volume of clinical "products" that the hospital produces, and the patterns of cost and resource use associated with them.

Important steps toward development of this type of integrated information system were taken during 1981. RAHC developed a capability to provide each of its member hospitals with two basic documents: a financial analysis of the hospital's own unit costs and staffing levels during 1980 compared with 1978 and compared to the experience of similar hospitals in Rochester or elsewhere; and a clinical analysis focusing on patients' length of stay at that hospital compared with similar data from Rochester area hospitals collectively, and from a group of similar hospitals elsewhere. The clinical analyses are currently being enlarged to include data on usage of ancillary services such as laboratory, x-ray, medical supplies, etc. Eventually the clinical and financial analyses will be merged into an integrated information system aimed at helping hospital managers, boards and medical staffs make better resource allocation decisions for their patients and institutions.

The ability of the data system to associate patterns of care with costs underscores the importance of physician involvement in hospital management—since physician decisions determine most hospital resource use. The implications carry over into medical education as well, as it becomes more clearly understood that health care professionals require training to respond to new opportunities for combining managerial and treatment skills.

Since information of the caliber provided by the community data base has never before been available, institutional management and information systems are being modified in order to use the new data to maximum advantage. Several hospitals have applied for HEP Contingency Fund assistance in integrating this new resource into their management structures.

Mental Health

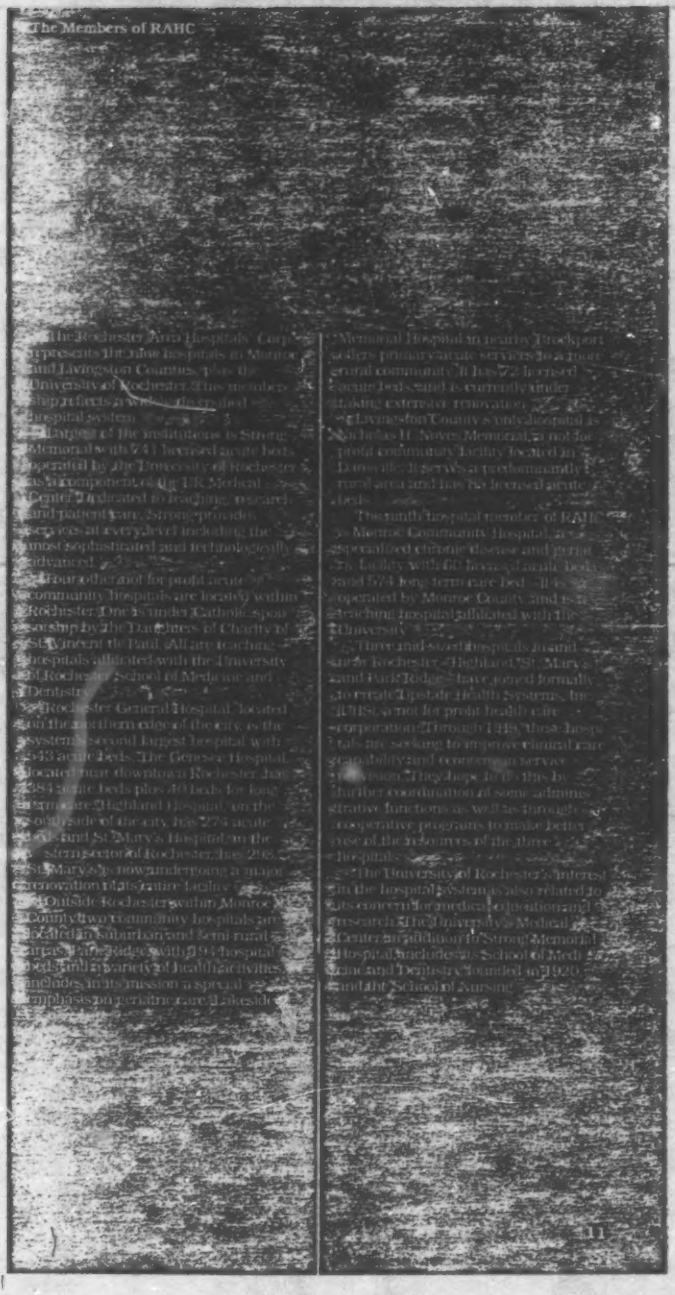
RAHC's skills in community-wide approaches to hospital service delivery and finance are now being applied in the mental health field. During 1981 work was begun on the Monroe-Livingston County Single Service System Demonstration Project, one of three being funded by the New York State Office of Mental Health. The purpose of the three-year project is to develop a more comprehensive mental health service system in the two counties, by improvements in coordination and financing.

During its first year the existing system of mental health services was reviewed and possible models for an integrated system were identified. The model being proposed will be based upon a federation of providers that would include agencies receiving state and local mental health funds. These agencies would thus be joined in a common commitment to providing care to the community at risk, particularly the chronically mentally ill. The integrated system would help provide a focal point for coordination of mental health services, would include new payment incentives for cost-effective care, and would develop a community-wide data base to assist participating providers and agencies.

Coming in 1982

In the coming year RAHC will continue to work with other agencies, providers and payors to improve the community's ability to serve patients requiring long-term care. An important focal point will be the proposed capitation reimbursement system for hospitalized patients needing long-term care. By establishing rates which recognize varying disability characteristics of individual patients, the proposed system would enable long-term care providers to accept a larger proportion of heavy-care patients without undue risk of financial loss.

A continuing theme through virtually all RAHC activities and planning for 1982 and beyond relates to recognition by hospitals and medical staffs of their roles not only as providers of acute care, but also as part of a continuum of health care services required by the community. Awareness of this larger responsibility is growing on many fronts as RAHC joins in the search for long-term care solutions, in the development of a Community Hospital Plan, and in the evolution of a more effective management system to provide hospital care that the community can afford.


The Members of RAHC
11

Rochester Area Hospitals' Corporation
Balance Sheets
As of December 31, 1981 and 1980

ASSETS	1981	1980
Unrestricted Funds		
Cash and Temporary Investments	$ 24,132	$ 161,599
Due from Restricted Fund	23,808	
Accounts Receivable	1,043	34,588
Prepaid Expense	15,636	1,966
Fixed Assets, at Cost, Less Accumulated Depreciation of $13,656 and $5,607	65,747	40,628
Total Unrestricted Assets	130,366	228,781
Restricted Funds		
Minicap Contingency Fund Cash and Temporary Investments		$ 604,495
HEP Contingency Fund		
Cash and Temporary Investments	$5,283,752	$3,625,497
Due from Member Hospitals	1,109,064	537,598
Loan Receivable from Subsidiary	127,800	
	86,520,616	$4,163,095
LIABILITIES AND FUND BALANCES		
Unrestricted Funds		
Accounts Payable	$ 102,053	$ 26,756
Accrued Payroll and Payroll Taxes	53,612	14,710
Deferred Grant Income	15,343	185,818
Total Liabilities	171,008	227,284
Unrestricted Fund Balances (Deficits)		
Operating	(106,389)	(39,131)
Fixed Asset	65,747	40,628
	(40,642)	1,497
Total Unrestricted Liabilities and Fund Balances	$ 130,366	$ 288,781
Restricted Funds		
Minicap Contingency Fund Balance		$ 604,495
HEP Contingency Fund		
Due to Unrestricted Fund	$ 23,808	
Fund Balance	6,496,808	$4,163,095
	$6,520,616	$4,163,095

Rochester Area Hospitals' Corporation
Statements of Activity
For the Years Ended December 31, 1981 and 1980

	UNRESTRICTED FUNDS						RESTRICTED FUNDS			
	Operations and Fixed Assets	Data Base & Clinical Analysis	John A. Hartford Foundation Grant	OMH Grant Single Service System	Total		Minicap		HEP	
					1981	1980	1981	1980	1981	1980
Revenue and Support										
Dues from Member Hospitals	$360,000				$ 360,000	$328,096				
Grant Income			$176,756	$208,789	385,545	353,152				
Interest Income	16,545				16,545	29,887				
	376,545		176,756	208,789	762,090	711,135				
Expenses										
Salaries and Benefits	251,973	$158,960	88,906	95,003	593,531	303,714				
Office Supplies and Expenses	76,335	33,405	16,047	21,769	147,556	97,393				
Consulting and Other Professional Fees	133,347	222,143	71,714	88,232	515,436	291,548				
	460,955	413,808	176,756	205,004	1,256,523	692,655				
Excess (Deficiency) of Revenue and Support Over Expenses	(84,410)	(413,808)		3,785	(494,433)	18,480				
Capital Additions (Expenditures)										
Amounts Received and Receivable from Member Hospitals							$ 21,853		$4,415,401	$3,957,705
Interest Earned							60,947	$ 55,570	828,481	205,390
Contingency Fund Disbursements							(687,295)		(2,457,875)	
Fund Balances (Deficit), Beginning	1,497				1,497	(16,983)	604,495	548,925	4,163,095	
Transfers										
Fixed Asset Acquisitions	3,765			(3,765)						
Board-designated Transfers	38,486	413,808			452,294				(452,294)	
Fund Balances (Deficit), Ending	$ (40,642)				$ (40,642)	$ 1,497		$604,495	$6,496,808	$4,163,095

The preceding summary data were extracted from the audited financial statements of Rochester Area Hospitals' Corporation for the years ended December 31, 1981 and 1980. A copy of the complete financial statements and the independent auditors' report thereon may be inspected at the offices of the Corporation upon request.

RA
HC

Rochester Area
Hospitals' Corporation
220 Alexander Street, Suite 508
Rochester, New York 14607 716-546-3280

James A. Block, M.D.
President

August 12, 1982

The Honorable David Durenberger
Chairman, Subcommittee on Health
United States Senate
Committee on Finance
Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator:

Thank you for your letter of July 30th requesting my reply to certain questions which should be answered for the record of the June 23, 1982 hearing on State hospital payment systems of the Subcommittee on Health. The following are the replies which should be entered in the record.

1. Who determines the rate of payment to your member hospitals? The rate of payment to the member hospitals is determined according to a contract defining annual revenue available to each participating hospital. The amount of revenue a hospital will receive is based upon its actual costs in 1978 (the base year of our payment program, used because it was the most recent year for which audited cost reports were available at the time our program was implemented in 1980), plus inflation trend factors that are computed, plus certain allowances for patient volume, new projects approved by the State Health Department, and a one percent adjustment added to the trend factor in 1979 and 1980 to improve the working capital position of the hospitals.

2. Are differences between teaching and nonteaching hospitals taken into account in calculating the rate of payment? Such differences among hospitals would be reflected in each hospital's payment rates only to the extent that they were already reflected in 1978 cost structures of hospitals or related to State Health Department approved projects approved after 1978.

3. In what respect is your program voluntary? Can member hospitals withdraw at any time? The experimental payment program is based on a contract among hospitals and payors which was entered into voluntarily by all parties. While there is considerable community peer pressure to continue to participate it would be possible for a member to withdraw on a contract anniversary date. All of the hospitals are committed to reviewing members' concerns and resolving issues as they arise on the assumption that this will enable continued participation of all in the program, which is viewed as having considerable benefits to the community.

Sincerely,

James A. Block, M.D.
President

JAB/k

STATEMENT OF GENNARO VASILE, PH. D., EXECUTIVE DIRECTOR, STRONG MEMORIAL HOSPITAL, UNIVERSITY OF ROCHESTER, ROCHESTER, N.Y.

Dr. VASILE. Thank you, Senator.

I would like to begin my remarks by indicating that I am the executive director of the University of Rochester Strong Memorial Hospital. An appropriate perspective on my comments can be perceived via some comments that were made by hospital administrative colleagues 3 years ago when I decided to leave Virginia and to go to New York State. They wanted to know whether I needed to have my head examined for going into a State that was as heavily regulated as New York State and where hospital administrators were actually fleeing the State because of the perceived inability to manage the hospital system with the State exerting such a great influence.

Senator DURENBERGER. What did you tell them then, and what do you tell them now? [Laughter.]

Is that the subject of your presentation?

Dr. VASILE. What I told them at the time was that I was going to New York State, and specifically Rochester, N.Y., because of the possibility of a reimbursement experiment in Rochester that could demonstrate that other than regulated systems could contain the rate of increase in hospital costs.

So what I would like to do is to provide two perspectives: one perspective concerning the State's regulated system; and then the perspective of a hospital administrator within the hospital experimental payments program, the program that Dr. Block oversees.

The New York State system of prospective rate control has been effective in containing the rate of increase in hospital costs. No one can deny that.

Between 1977 and 1981, the national rate of increase in hospital costs ranged from approximately 14 percent to 19 percent. Between 1977 and 1981 in New York State, the annual rate of increase in hospital costs ranged from approximately 6 percent to 12 percent—better than a 50-percent differential.

The price for this effectiveness in containing costs has been the rapid erosion of the financial base of New York State's hospitals, which, in turn, is limiting these hospitals' ability to adequately serve the health-care needs of the State's citizens.

In each year between 1976 and 1980 over 75 percent of our State's acute care hospitals incurred operating losses. Over that period, those loses amounted to $1.2 billion. Exhibit 1 in my material lists each year; and you will notice—75 percent is conservative.

I might add that the 1980 figure for an operating surplus of $16 million for the State's hospitals included $8 million from the Rochester hospitals under the experimental payments program.

New York State's hospitals cannot survive long with these kinds of financial results. Currently they are borrowing more money at higher interest rates, which ultimately increase reimbursement rates. They are using philanthropic funds to reduce operating losses; they are spending depreciation funds reserved for replacement of plant and equipment; they are curtailing services; some are seeking bailout funding from governmental sources; and some go bankrupt or out of business, as 50 have done.

I would like to make a comment on Mr. Schramm's note that hospital closures shouldn't concern us too much because schools and other kinds of industries are closing in New York State.

It is one thing to plan the closure of a health care facility. It is another thing to subvert it through the reimbursement system. The citizens of those areas served by the hospitals might have something to say about those closures.

The fiscal viability of New York State hospitals has reached a crisis point, and policymakers are looking for alternatives to the present system. In fact, consensus has emerged in New York State around a legislative proposal that would significantly change the system. It is called the Lombardi legislation, and I won't speak to that. Perhaps our representative from the New York State government will.

Meanwhile, under the waiver and demonstration provisions of the medicare program, and with the support of the State, I might add, and local government, HCFA, Blue Cross, and local industries, nine hospitals in the Rochester area of New York State are successfully demonstrating an alternative to State-controlled systems of rate regulation.

The alternative is a locally controlled prospective system of reimbursement called the Rochester area hospitals experimental payments program, or HEP.

Exhibit 2 in my statement indicates the experience of Rochester hospitals in two periods of time, between 1977 and 1979, when they were under the State system, and from 1980 through 1981 under the HEP program.

You will notice that the Rochester hospitals compared very well with the rest of the State in terms of containing costs under the State system. When the hospitals went under the HEP program you will notice a significant decrease or a better performance than the State as a whole in terms of containing costs. Dr. Block has cited those figures as well.

Under HEP, for example, in 1981 the Rochester area hospitals were able to contain costs to approximately 10 percent, while costs

in the State increased at the rate of 12 percent; and that's roughly a 20-percent differential.

The dramatic aspect of that, as Dr. Block has pointed out, is that that was done voluntarily. Services haven't been curtailed, and exhibit 3, which lists hospital utilization in Rochester as well as critical hospital financial indicators such as net operating margin and current ratios, shows significant improvements.

The hospital industry in the Rochester area was on the verge of insolvency in 1979, and it is slowly but surely making a recovery.

The purpose of the HEP program is to demonstrate that the Rochester area hospitals can voluntarily contain the rate of increase in hospital costs while maintaining or enhancing the quality of services. HEP's design provides incentives and flexibility which facilitate, as Mr. Derzon indicated, responsible local planning and decisionmaking.

A prospectively determined cap on inpatient and outpatient revenues of the participating hospitals is one major feature of the design. The cap is based on 1978 operating expenses trended forward, and the cap is adjusted each year for inflation, approved certificate-of-need projects, and volume changes.

There are also positive incentives. The basis for the revenue cap determination in subsequent years is independent of expenses. Individual hospitals retain the difference between revenues and expenses, contrary to other systems where lower expenses result in a reduction in future reimbursement.

One of the major benefits of this system is improved cashflow. Each of the hospitals receives one/fifty-second of their prospectively determined payment each week. Since 80 percent of the hospital business is under the experiment, a significant amount of cash enters the system weekly.

There are other features as well. One of the critical ones—and Dr. Block wouldn't speak for his own organization—is the place of Rochester Area Hospitals Corp. within the Rochester system. RAHC is a consortium that was formed by the hospitals for joint planning and community problem solving. It administers the contract and it facilitates communitywide planning and problem solving. It has been very effective in administering the contract and assisting the hospitals to adapt to this new program.

These features have resulted in not only the financial results that have been referred to earlier but also the following:

First, the development of a service-specific community hospital plan. Can you imagine nine hospitals getting together and essentially planning on a service-specific basis the number and location of beds in the community? I am hard pressed to find another community in the country that has done that. Rochester has done that.

Second, the development of a communitywide data system.

Third, a major expansion of cardiac surgery.

Fourth, the establishment of several ambulatory surgery facilities.

Fifth, several new innovative programs to address more appropriately the health-care needs of the elderly.

New York State's publicly regulated system of hospital financing has contained the rate of increase in hospital costs to levels significantly below the national experience. The State has achieved that

performance at the expense of the financial viability of New York State hospitals.

Reform is necessary, and viable alternatives exist. The Rochester experience with HEP is demonstrating one such alternative. And I would ask that in the deliberations regarding prospective reimbursement that this experiment be given serious consideration as to its design features.

Senator DURENBERGER. Well, that's why you are here.

[The prepared statement of Gennaro Vasile and answers to questions from Senator Durenberger follow:]

TESTIMONY

OF

GENNARO J. VASILE, Ph.D.

HOSPITAL FINANCING IN NEW YORK STATE

AND

ROCHESTER, NEW YORK

DIVERGENT APPROACHES AND RESULTS

My name is Gennaro J. Vasile, Ph.D.. I serve as the Executive Director of the University of Rochester Strong Memorial Hospital in Rochester, New York. I am here today to:

- Describe New York State's regulated system of hospital financing and highlight the results of the system.
- Review the recent experience of nine Rochester area hospitals under the Hospital Experimental Payments Program (HEP) as an example of a successful voluntary alternative to state-controlled rate regulation.

I will deal with these subjects briefly. A number of attachments describe more fully the details of New York State's system of hospital financing and the HEP Program.

HOSPITAL FINANCING IN NEW YORK STATE

The New York State hospital financing system is based on a prospective rate setting system. This system accounts for approximately one-half of the hospital costs in New York State. Reimbursement rates under this system are based on total hospital operating costs, adjusted by inflation and standards of efficiency, such as 1) average costs of peer group hospitals; 2) occupancy and length of stay standards for facilities; and 3) prior year utilization rates.

The New York State system of rate regulation is effective. From 1977-1981, the percent increase in hospital costs in New York State was considerably lower than that of nation-wide hospitals. However, the impact on New York State hospitals indicates problems with the system. As shown in Exhibit I, during the period 1976-80, over 75% of all hospitals incurred operating losses. Those losses amounted to $1.2 billion over five years. These losses are measurable and significant and are compounded by recent cuts in both State and Federal funding of health care programs.

How do hospitals survive these deficits? They:

- Borrow more money, increasing reimbursement rates;
- Use philanthropic funds to reduce operating losses;
- Spend depreciation funds reserved for replacement of plant and capital equipment;
- Curtail service;
- Seek "bailout" funding from governmental sources

The fiscal viability of the New York State hospital system has reached a crisis point. New York State, realizing the danger of this situation, is beginning to explore alternatives to the present system. Nine hospitals in the Rochester, New York area are currently addressing the problem, responding to many of the pressures being felt state-wide. It is their belief that a voluntary system is preferrable, both in terms of quality and cost of health care, to a state-controlled system of rate regulation.

ROCHESTER HOSPITALS UNDER HEP

Exhibit II compares the percentage change in the consumer price index for the period 1977-1981, to the percentage change in hospital expense for the nation, New York State and the Rochester area. Rochester hospitals operated under the state-regulated

EXHIBIT I

PERCENTAGE OF NEW YORK STATE HOSPITALS WITH OPERATING SURPLUS/LOSSES: 1976-1980

Year	Operating Losses in Dollars	Percentage of Hospitals with Losses	Operating Surplus in Dollars	Percentage of Hospitals with Surplus
1976	$167,000,000	79%	$ 12,000,000	21%
1977	$230,000,000	81%	$ 17,000,000	19%
1978	$247,000,000	76%	$ 20,000,000	24%
1979	$263,000,000	80%	$ 15,000,000	20%
1980	$256,000,000	81%	$ 16,000,000	19%

Total New York State Hospitals: 1976-1980 = 243.

Source: Hospital Association of New York State, 1980 Fiscal Pressures Suvery.

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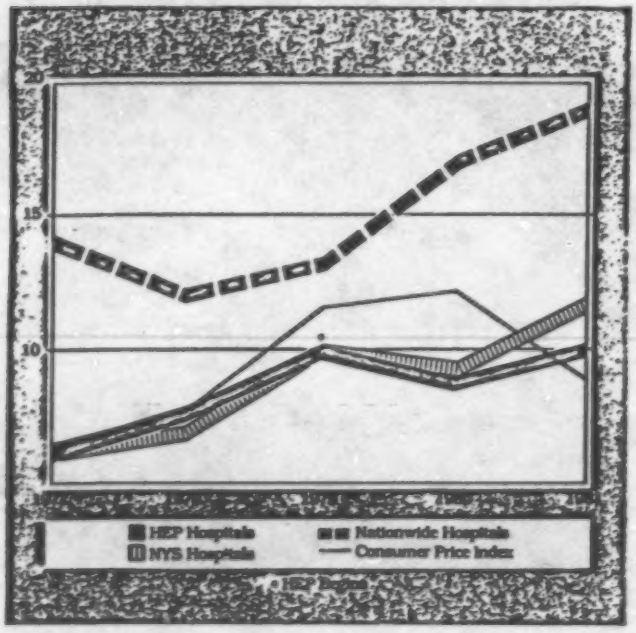
EXHIBIT II

TREND IN HOSPITAL EXPENSE 1977-1981
PERCENT INCREASE OVER PREVIOUS YEAR



reimbursement system for the period 1977-1979. The performance of the Rochester hospitals was equal to or slightly above the industry as a whole in New York State. The performance of these local hospitals was still significantly better than the nation's hospitals for that period. They achieved that performance by eliminating jobs and eroding their asset bases.

Local concern among the hospitals, trustees, physicians, and industrial leaders over the long-term financial viability of Rochester's hospitals led to the formation of the Rochester Area Hospital Corporation (RAHC). The Corporation was founded to facilitate community-wide hospital planning and problem-solving. Working with the support of local government, Blue Cross, the State Health Department, and the Federal Health Care Financing Administration, the leadership of RAHC was able to develop a new approach to the problem of cost containment -- HEP.

As Exhibit II indicates, HEP went into effect on January 1, 1980. Given the HEP Program design, which I will summarize in a moment, the results are dramatic. Percent increases in 1980 and 1981 for HEP hospitals were considerably less than that of the national average and significantly less than tightly regulated New York State hospitals. Specifically:

	HOSPITALS		
	HEP	N.Y.S.	NATION
1980	9.1%	9.5%	17.0%
1981	10.0%	12.0%	18.7%

As Exhibit III demonstrates, this cost containment performance was achieved while maintaining service levels and improving generally accepted indicators of financial health.

What is dramatic about these results is that they have been achieved without Federal and State reimbursement regulations which were waived as part of HEP's experimental design. In fact, the purpose of HEP is to demonstrate that Rochester area

EXHIBIT III

TRENDS IN ROCHESTER AREA HOSPITALS UTILIZATION AND FINANCIAL INDICATORS

1979 - 1982

Hospital Utilization

	1981*	1980	1979	1978
Admissions	99,492	104,263	107,013	105,354
Patient days	845,704	835,692	841,697	837,356
Emergency dept. visits	197,201	208,048	207,931	206,631
Clinic visits	338,903	336,788	316,320	300,969

Hospital Financial Indicators

	HEP Hospitals			Industry
	1981*	1980	1979	average
Current Ratio *Current assets ÷ current liabilities*	2.33	1.53	1.36	1.88
Average Collection Period *Net days in A/R*	34.6	40.5	52.5	59.2
Net Operating Margin *Net operating income ÷ operating revenue*	.011	.012	(.01)	.022

**These data are preliminary and include estimates based on hospitals' submissions to RAHC.*

hospitals can voluntarily contain the rate of increase in hospital costs while maintaining or enhancing the quality of services provided to area residents. HEP's design provides incentives and flexibility which facilitate responsible local planning and decision-making. Major design features include:

- A prospectively determined cap on inpatient and outpatient revenues of the nine participating hospitals:
  - The cap is based upon 1978 actual operating expenses
  - The cap is adjusted each year for inflation, approved "Certificate of Need" projects and volume changes
- Positive incentives, because once the initial cap is established, it is a revenue cap. The basis for revenue cap determination in subsequent years is independent of expenses. The individual hospital retains the difference between revenues and expenses -- contrary to other systems lower expenses do not result in a reduction in future reimbursement.
- Guaranteed weekly revenue to each hospital:
  - From contract payors: Blue Cross, Medicaid, and Medicare
  - Contract payors account for approximately 80% of aggregate hospital revenue
- Provision for a community-wide contingency fund that is administered by RAHC. The fund is used for "Certificate of Need" and volume adjustments, data system development expenses, case mix adjustments, research activities, and unforeseen expenses.
- Waiver of Federal and State reimbursement regulations for the durationof the experiment.
- A voluntary local organizational linkage -- RAHC -- for contract administration and community-wide planning and problem-solving.

These features have resulted in not only the financial results referred to earlier, but also the following: development of a service-specific community hospital plan; development of a community-wide hospital data system; a major expansion of cardiac surgery capacity; implementation of a cardiac rehabilitation program; establishment of ambulatory surgery facilities; and several new innovative programs to address more appropriately the health care needs of the elderly.

SUMMARY

New York State's publicly regulated system of hospital financing has contained the rate of increase in hospital costs to levels significantly below national experience. The State has achieved such performance at the expense of the financial viability of New York State hospitals. Reform is necessary and viable alternatives exist. The Rochester experience with HEP is demonstrating one such alternative.

Attachment A

WHO PAYS FOR HOSPITAL CARE?

Hospital services are funded primarily in one of two ways: through reimbursement by third party payors or by hospital established charges to private paying patients.

A brief look at each of the major payment sources sets the framework for an examination of hospital financing in New York State.

Medicare – Medicare is a totally federally funded health care beneficiary program for persons ages 65 and older. In New York State, Medicare is the payor for approximately 38% of all hospital care.

Unlike other major third party payors in New York State, Medicare reimburses hospitals on a *retrospective* basis. Under a retrospective system, hospitals are reimbursed during the year a portion of what their expected costs for treating Medicare patients for that year will be. After that rate year is audited and actual costs are determined, the rates are adjusted to reflect that total share of the hospital's overall costs which Medicare will reimburse.

Also under Medicare's retrospective reimbursement system, certain costs associated with operating a hospital, such as costs related to maternity and pediatric services, are "carved out" or totally disallowed from payment consideration. The reason for the carve-out is that persons over 65 are not normally expected to utilize these services. The carve-out often results, however, in hospitals being reimbursed under Medicare for less that their actual cost of providing services.

Because actual audited costs (minus the carve-outs) are reimbursed under this retrospective system, there are no incentives for institutions which control their spending. Further, as hospitals do not know until well after the fiscal year how much Medicare will be reimbursing in total, hospitals have no precise revenue expectations and can not budget nor plan accurately.

Medicaid – Medicaid is a government funded health care beneficiary program for persons with incomes under a statutorily established limit. The program is funded jointly by the federal government (50%), the State government (25%) and county governments (25%), and pays for 19% of all inpatient hospital care in New York.

Reimbursement rates for Medicaid are set in New York by the Office of Health Systems Management under a methodology approved by the New York State Hospital Review and Planning Council.

It is an average cost *prospective* reimbursement system, under which hospitals are reimbursed fixed rates which are established in advance of

the billing year so that institutions can anticipate revenue and budget appropriately. The rates are derived from base year costs (two years prior to the rate year) to which an inflation factor is added for the two intervening years to project increases in cost to a facility during the rate year.

The underlying concept of prospective reimbursement is that it projects costs as they should be reasonably expected to occur and, as such, encourages hospitals to plan ahead. Further, it anticipates that efficiencies achieved in the base year should be continued through the rate year.

A detailed description of Medicaid reimbursement in New York follows in the next section of this report.

Blue Cross – Blue Cross is a not-for-profit corporation which provides health care benefits to its subscribers. There are seven Blue Cross plans in New York offering a variety of coverage plans. The combined Blue Cross plans pay for approximately 26% of hospital care in New York.

Blue Cross reimburses on an average cost basis, as does Medicaid. While the Blue Cross plans calculate their own rates of payment to hospitals, the rates must be certified by the Office of Health Systems Management as being related to the efficient production of services before being approved for payment by the Superintendent of the State Insurance Department.

Worker's Compensation and No-Fault Insurance – Worker's Compensation and No-Fault Insurance programs also reimburse on a prospective, average cost basis. Reimbursement rates for these programs are calculated by the Office of Health Systems Management. Only 6% of hospital services are reimbursed by these two programs.

Private Insurance Carriers and Private Payors – Private insurance companies do not reimburse hospitals on the basis of average cost, as do Medicaid, Blue Cross, Worker's Compensation and No-Fault Insurance. Nor do they pay on a retrospective basis as does Medicare. Instead, private insurance carriers pay hospital charges – the price established by each individual hospital for the services it provides to private paying patients.

Private insurance payments and individuals paying out of pocket for hospital care together pay for 11% of the hospital care delivered in New York. Since 1978, annual increases in private charges have been controlled under the Hospital Charge Control Law. This law requires that hospital charge increases be kept within the amount determined by the statutorily enacted Panel of Health Economists to account for inflation.

REIMBURSEMENT CONCEPTS: WHAT THEY ARE AND HOW THEY WORK

As noted in the preceding section, Medicaid, Blue Cross, Worker's Compensation and No-Fault Insurance reimburse hospitals for care provided to their beneficiaries under an average cost, prospective reimbursement system. What this prospective system is and how it is applied is the subject of this section of *Trustee Topics*.

The Basic Formula – The prospective payors under State control – Medicaid, Blue Cross, Worker's Compensation and No-Fault Insurance – reimburse hospitals on the basis of average daily cost. To derive average daily cost, the total cost of operating the hospital during the base year is calculated. (Note: These costs are reported to the OHSM on each hospital's annual financial report). Standards of efficient operation are then applied to the operating costs, and, in some cases, certain hospital costs are disallowed, or subtracted from the total. To the remaining allowable operating costs, a percentage increase is applied to account for inflation from the base year to the rate year. For example, for the rate year 1980, approximately 16% was added to the allowable 1978 costs to account for inflation.

Once the inflation, or trend factor, is applied, capital costs are added and the resulting total is divided by the number of days of patient care rendered in the base year. The result: a daily, or per diem, rate of reimbursement which reflects the projected allowable cost of providing care during the rate year.

A word here about the trend factor. This factor is developed by a statutorily established independent panel of economists and is designed to project, as precisely as possible, increases in costs as a result of wage and price movements in the general economy. The factor is adjusted every six months to take into consideration new economic developments which affect the cost of doing business. Resources used for projecting economic movement by the panel include the Consumer Price Index, the Wholesale Index, and a number of economic indicators particular to the health care industry.

Standards of Efficiency – New York State law governing the Medicaid program requires that rates of reimbursement to hospitals be "related to the efficient production of service." Standards which reflect efficient operation have been developed incrementally over the years, and are applied to a hospital's reported costs to obtain the maximum amount

allowable under law. The most important of these measures of hospital efficiency are peer groupings, occupancy standards, and length of stay standards.

Peer groupings — The technique used to identify maximum allowable hospital costs for reimbursement is a normative approach called peer groupings. This technique, which has been upheld in court decisions over the past few years as an equitable means of determining efficient cost, groups hospitals on the basis of comparable indicators such as case mix, service mix and utilization. The group average cost plus 5% becomes the standard, or reimbursement "ceiling," for all members of the group.

Hospitals in a group whose costs are above the group average are reimbursed only at the group ceiling. Hospitals whose costs are below their group's average receive full cost reimbursement.

It is important to emphasize that all hospitals in a group are not reimbursed on the basis of the *most* efficient hospital in the group. Use of the group average provides a relief corridor for the least efficient among the group, while simultaneously encouraging elimination of inefficiencies.

When making decisions about current and future hospital operations, trustees should identify what, if any, costs were disallowed for reimbursement as a result of peer group ceilings. This information is readily available on the complete print-outs of each facility's reimbursement rate calculations, which were sent to each hospital in November.

Occupancy Standards — Burdensome costs associated with duplicative, underused services and unnecessary (and empty!) hospital beds led to the development of hospital occupancy standards. These standards, adopted for all inpatient services by 1975, are utilization levels deemed necessary for the efficient operation of a service.

Cognizant of utilization fluctuations particular to small geographically isolated hospitals, two sets of standards for basic services were adopted:

Services	Urban	Rural
Medical/Surgical	85%	80%
Pediatrics	75%	70%
Maternity	75%	60%

As mentioned earlier, a hospital's per diem reimbursement rate is calculated by dividing its total allowable costs by the days of care rendered. However, in the case of a hospital whose occupancy rate falls below the standards, that hospital's total cost is *not* divided by the actual number of days provided, but rather by the number of days that would have been provided had the hospital achieved the occupancy

than it did in 1978 (keeps utilization below its target), participating third party payors will reimburse at the full per diem rate for each day of care actually provided, plus 80% of the daily rate for each additional day over actual utilization to the target. This 80% will compensate the hospital for costs which remain fixed, such as mortgage payments and fuel costs, regardless of the number of patients it treats.

Conversely, if a hospital provides more days of care in 1980 than it did in 1978, or *exceeds* its volume target, the hospital will be reimbursed the full per diem rate from each of the participating payors for each of those days of care rendered up to the target, but only 20% of its rate for each day over target. The 20% payment is intended to cover the additional cost, such as meals, x-ray and lab work, for these additional patient days.

Thus, there is both a positive incentive to reduce unnecessary utilization and a negative incentive to increase utilization.

The volume target mechanism is perhaps the single most important element in the OHSM's long range approach to financing hospital inpatient care. It allows management of a facility the freedom to take efficiency promotion efforts and be rewarded for them. It removes the threat of financial harm to a hospital for eliminating unnecessary days of care. And, it removes some of the pressure felt by many institutions to recruit physicians in order to fill beds.

Medicaid, Blue Cross, Worker's Compensation and No-Fault insurance all participate in this volume adjustment mechanism.

FROM CONCEPTS TO PER DIEMS

The reimbursement process, while administered by the OHSM, is one which involves hospital representatives, a broadly representative Statewide Council, other agencies of State government and the federal government. How the methodology by which hospitals are reimbursed comes into being and options available to hospitals which don't "fit" the methodology are the subjects of this section.

Rate-setting — Reimbursement rates are calculated under a formula which is laid out in regulation in a section of the Administrative Rules and Regulations of the Department of Health called Part 86.

The New York State Hospital Review and Planning Council is the body authorized by statute to adopt the hospital reimbursement regulations found in Part 86.1. This 31-member State Council includes representatives from the hospital industry, government, Blue Cross, consumers, the medical profession, the health systems agencies and other health industry sectors. The Council meets approximately monthly at the Blue Cross-Blue Shield building on Third Avenue in

Manhattan. All the proceedings of the Council are open to the public. Hospital trustees would find the meetings interesting and pertinent, and should attend when their schedules permit.

Recommendations for changes or improvements to State reimbursement regulations are developed by the OHSM and are forwarded to the State Council for their review and deliberation. The Council's Fiscal Policy Committee reviews in great depth the proposed methodology, holds open meetings to discuss the proposals at which all interested parties are welcome to speak, and makes whatever changes, additions or deletions they believe necessary for Council consideration on the basis of their analysis and the public comments. This process normally begins in June or July preceding the year for which the proposed methodology would go into effect. In September, the Fiscal Policy Committee presents the proposal and its review to the full Council for their information. The Council members review the proposals, obtain additional comments from interested parties, and may request alterations before final Council action is taken. Proposed regulations are also published in the State Register for public notice and comment.

Once the methodology is approved, Medicaid rates are then calculated by the OHSM and are forwarded to the State Division of the Budget for the Budget Director's approval before being mailed to each institution.

Blue Cross rates are calculated under methodologies similar to that used by Medicaid. Once calculated, they must be certified as "reasonably related to the efficient cost" of providing services by the OHSM Director and are then forwarded to the Insurance Department Superintendent for his approval. Worker's Compensation and No-Fault Insurance reimbursement rates are calculated by the OHSM and approved by the Director of the State Division of the Budget before publication.

Rate Calculation Sheets — Federal law requires that hospitals be notified of new Medicaid reimbursement rates 60 days in advance of the rate year. The OHSM publishes rates each year at the end of October, and sends the new rates, along with computer printouts of the actual rate calculation, to each facility.

The rate calculation sheets contain a wealth of information for hospital trustees. They indicate, as noted earlier in this report, to what extent the reimbursement rate for that individual facility has been adjusted to account for utilization, length of stay, or costs disallowed above group average. This information is important to trustees as they approve budgets for the upcoming year, initiate cost control programs and contemplate service changes.

Appeals – Any formula system of reimbursement must have some mechanism for handling significant, unique individual facility aberrations. A formalized appeal process has been developed to accomodate these unique situations.

Appeals for increases in Medicaid reimbursement are initiated by the appealing facility, and that facility is responsible for justifying why an increase should be approved. In most cases, this involves the preparation by the appealing facility of documentation and data to substantiate an appeal.

Because of the volume and complexity of appeals and the limited OHSM staff resources to review the appeals, a significant backlog of appeals accumulated in 1978. Many of these appeals, such as those concerning case mix, required new analytical technologies to adjudicate. The OHSM developed the necessary tools – technologies that didn't exist anywhere else in the country – to get the job done. All but a handful of hospital appeals for rate years 1975 through 1979 are now completed.

Appeals of Blue Cross rates are reviewed by the individual Blue Cross plans, and any rate changes based on appeal are then certified by the OHSM and forwarded to the Insurance Superintendent for approval.

GETTING PAID

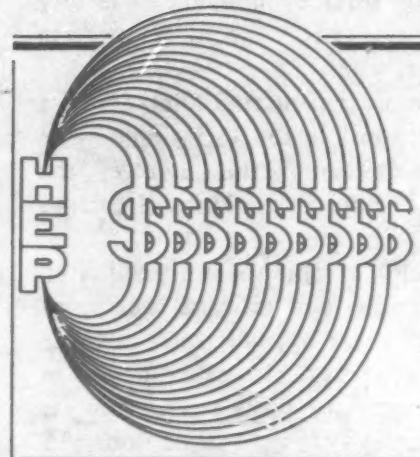
To be reimbursed for services rendered, hospitals must submit claims to patients' third party payors. In cases of private paying patients, bills are sent directly to the patient.

All major third party payors, including Medicare, Medicaid, Blue Cross, Worker's Compensation and the commercial insurance companies, use a uniform bill called the UBF–1 for claims. This uniform bill, developed by the OHSM in conjunction with the Statewide Planning and Research Cooperative System (SPARCS), eliminates the dozens of claim forms hospitals previously had to use for the variety of payors.

For services rendered to Medicaid beneficiaries, claims must be submitted to local social services districts (in New York City, to the Medicaid Management Information System). Claims for Blue Cross patients are submitted directly to the Blue Cross plans.

Although claims are also filed with the Blue Cross plans for Medicare beneficiaries, Medicare advances regular bi-weekly payments to hospitals under a periodic interim payment, or PIP, plan. At the end of the year, the money paid to the hospital in PIP payments is compared with the actual number of claims submitted, and any necessary payment adjustments are made.

Attachment B



Experimental payments program

It's working

by James A. Block, M.D., Donna I. Regenstreif, Ph.D. and Leonard J. Shute

Editor's note: In 1967, Congress authorized the Medicare program to conduct healthcare experimental payment projects that would provide incentives for economy while maintaining or improving quality of health services.[a] It reconfirmed, in 1972, the Medicare program's authority to enter into incentive contracts with healthcare providers in which payment would be based on negotiated rates.[b]

The Health Care Financing Administration (HCFA) has a large number of waiver and demonstration programs, one of the most important being the Rochester Area Hospitals' Experimental Payments Program. It is a voluntary experiment not designed by or for a state rate-setting agency. It has resulted in significant improvements for its area's hospitals' financial conditions. *HFM* readers will be especially interested because components of this program may be usable in other parts of the country.

THE SOLVENCY OF ROCHESTER, New York, hospitals was seriously threatened as a result of rigorous New York State hospital cost containment policies that limited payments to hospitals from Blue Cross and Medicaid initially, and eventually brought hospital charges under state control.

This was happening despite a background of economic factors contributing to economy in healthcare costs in the area.

Prior to the Hospitals Experimental Payments (HEP) program, payment mechanisms for these hospitals were under government regulations that were sometimes contradictory, did not permit accurate hospital income prediction and invariably resulted in hospital administrations losing revenue when cost reductions were achieved.

Under these circumstances hospital administrators found it difficult to establish policies that could enhance patient care *and* maintain financial solvency.

Moreover, their ability to budget and plan effectively was adversely affected by frequent changes in reimbursement rules and regulations. By 1978, the solvency of the hospital system in Rochester and elsewhere in the state was seriously threatened, and some hospital administrators had resorted to liquidating portions of their endowment funds to underwrite routine activities.

A local system of self-control

Rochester hospital trustees were determined to develop a positive alternative to these difficulties. They would, on a voluntary basis, demonstrate their commitment to a local system of *self-control*. This system required a predictable fiscal environment to succeed.

It was against this background of difficulties that the Rochester Area Hospitals' Corporation (RAHC) was incorporated as a not-for-profit organization in July 1978,[c] after years of planning among the area's hospitals, their boards and medical staffs.

The HEP program was combined with information systems to enable community wide planning in response to community needs and ongoing efforts to assure quality and evaluate cost effectiveness of hospital services.

RAHC's initial task was to develop a payment alternative to test the assumption that a community, through voluntary local control and accountability, could simultaneously enhance its hospital system's excellence and control its rate of cost increase.

a. See Social Security Amendments of 1967, PL 90-97, Section 402 (a).

b. Social Security Amendments PL 92-603, Section 222 (b).

c. Area-wide hospital planning dates back over four decades; early efforts are described in *The Rochester Regional Hospital Council*. L.S. Rosenfeld and H.B. Mehover. Cambridge: Harvard University Press, 1968.

for Rochester-area hospitals

Thus, RAHC's mission is:

- To maintain and enhance the community's hospital system;
- Control the rate of cost increase of hospital services, ensuring the availability of needed hospital services in an era of increasing constraint on resources;
- Facilitate local decision making through enhanced communication and coordination;
- Maximize the cost effectiveness and benefit to the community of hospital services provided and planned.

The Hospitals Experimental Payments (HEP) program was developed to help achieve these goals. Its development was supported by dues from RAHC hospitals and a grant from The John A. Hartford Foundation of New York City. A contract was developed specifying the terms for a new hospital payment methodology consisting of a proposed prospectively determined community-wide cap on revenue for a three-year period to begin Jan. 1, 1980. It was signed by those representing all acute care hospitals in the area and by the Rochester Hospital Service Corporation (Blue Cross). The contract was forwarded to the State of New York, where it received approval from the Office of Health Systems Management and the Department of Social Services (Medicaid).

The U.S. Health Care Financing Administration (HCFA) approved the project in December 1979, and granted a waiver of Medicare and Medicaid reimbursement principles. HEP was implemented on Jan. 1, 1980; its term extended for an additional two years (through Dec. 31, 1984) with the agreement of all contracting parties at the end of 1980.

Nine hospitals are participating in the RAHC experiment; they range from two hospitals of under 100 beds in semi-rural communities to a tertiary care university medical center with more than 700 beds. In 1980, on entering the payment experiment, their aggregate expenses exceeded $270 million. They employed nearly 10,000 people and annually trained more than 600 residents in a variety of medical education programs. They serve a population of one million[d] and constitute the Northern Sub-Area of the Finger Lakes Health Systems Agency planning region.

The provision of needed high quality services presumes an understanding of the hospitals' major products and the association between patterns of resource use (or medical practice) and treatment costs. HEP offers predictable levels of revenue in support of the hospitals' activities. Concurrently, it creates a need for a clear statement of expected patient resource usage in order for a hospital to effectively plan, budget and monitor its performance. Thus, one important facet of RAHC activities has been the integration of all hospitals' financial, billing and discharge abstract information into a routine management reporting system. Individual hospital administrations use these reports in planning, management and quality assurance functions. On a community-wide basis, these reports assist in overall hospital system planning. HEP's payment approach thus offers hospital administrators totally different financial incentives plus a unique management and planning opportunity.

General features of HEP

HEP's general features are to promote the effective and efficient delivery of hospital services in the Rochester area and to maintain the solvency of the participating hospital administrations. HEP is predicated on the idea that a major cause of inflation in hospital costs is the faulty design of health payment systems. The incentives inherent in traditional payment systems, and New York's early efforts at state-wide regulation, do not promote

Continued on page 12

d. The two-county population is 750,000 and the nine-county regional referral area has a population of 1.2 million.

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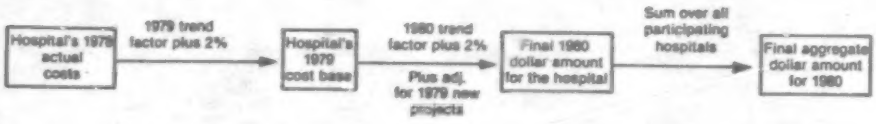
these purposes. HEP encourages hospital cost containment through the introduction of appropriate incentives in the hospital financing system that affect both inpatient and outpatient services.[e]

These new incentives are, for the most part, the results of two features of the HEP system. They are:

1) Payments of each hospital are based, after the first year of the program, on that hospital's preceding year's payments without regard to its incurred costs. Cost savings realized by the hospital thus accrue to its benefit throughout the program.
2) Total revenue available to the community's hospitals is determined in advance of each year of the program. The available revenue covers all of the hospitals' expenses, including incremental operating expenses associated with approved Certificate of Need (CON) projects, increases in volumes of services, and costs associated with unforeseen events. This feature gives the hospitals incentives to work together to avoid unnecessary duplication of service, while preserving the autonomy of each hospital.

Exhibit 1: Computation of 1980 final dollar amount


Hospital's 1978 actual costs
1979 trend factor plus 2%
Hospital's 1979 cost base
1980 trend factor plus 2%
Plus adj. for 1979 new projects
Final 1980 dollar amount for the hospital
Sum over all participating hospitals
Final aggregate dollar amount for 1980

Causes of hospital cost inflation

HEP addresses two principal causes of hospital cost inflation. They include:

1) *The volume problem*—The incentives of traditional reimbursement to reward high rates of admission, long lengths of stay and increasing resource use per admission;
2) *The planning problem*—Planning agencies' approval of projects under CON regulation neither reflects an accurate assessment of financial reasonableness nor links projected expenses with actual experience.

HEP's response to each of these issues is more diverse and clearly delineated than in any other hospital payment system in the United States today. These responses are:

1) *Volume:* Under HEP, hospital financial departments are compensated for increases in admissions according to a formula designed to discourage marginal admissions and to promote increased use of outpatient services. All payment for additional services is drawn from a contingency fund; thus hospital administrations are collectively at risk for unwarranted increases in volumes of service. Further, there is a 2 percent corridor before increased admissions are paid and a conservative marginal cost factor (40 percent) applied to payments for increased inpatient admissions. Further, hospitals receive no compensation for increased resource use per patient.
2) *Planning:* The operating costs of CON-approved projects are drawn from a community-wide contingency fund and are subject to negotiation between RAHC and the hospitals' financial staffs. Thus, the hospitals are collectively at risk for planning decisions and their associated costs; and there is expertise and incentive to improve cost effectiveness.[f]

HEP is a prospective payment system that uses the hospitals' 1978 allowable costs (defined in accordance with Medicare principles) as the basis for establishing payment levels for the five-year term of the experiment. Two calculations are fundamental to the system: 1) an overall limit on the annual net patient revenue for *all* hospitals called the "final dollar amount," and a limit on 2) an *individual* hospital's annual net patient revenue, which is the hospital's "final allowable cost base."

The final dollar amount, sometimes referred to as the "total revenue cap," was calculated for 1980 by projecting each hospital's 1978 base-year costs (adjusted for the incremental operating costs of CON-approved projects implemented between the base year and 1980) to the rate year, using in-

e. RAHC's chief reimbursement consultant in development of HEP was John S. Cook, D. Phil., former chief rate analyst with the Maryland Health Services Cost Review Commission. Certain features of the Maryland system and of the MAXICAP project are to be found in the HEP program. MAXICAP was a concurrent effort to develop a regional planning and reimbursement methodology which was developed with the cooperation of HCFA, National and Rochester Blue Cross, the New York State Hospital Association, and the Finger Lakes Health Systems Agency, but was never implemented. See Sorenson, A.A., Ph.D. and Seward, E.W., M.D.: "An Alternative Approach to Hospital Cost Control: the Rochester Project;" *Public Health Reports*. 93:311-317, (1978).

f. During recent negotiations in connection with CON incremental operating expenses for increased capacity for open heart surgery, the final negotiated level of incremental expense approved by the RAHC board was some $450,000 lower than had been originally proposed by the sponsoring hospitals.

flation or "trend" factors to account for price increases in the goods and services that hospital managers use and a 1 percent annual provision for working capital. In 1981 and subsequent years, the final dollar amount is based on the preceding year's final allowable cost bases (which are explained below), exclusive of adjustments for volume, plus an amount for inflation.

Final dollar amount

In addition, 2 percent is added each year to the trend factors to allow payment for increased volumes of hospital services, incremental operating expenses associated with CON projects, unforeseen events and various other special projects consistent with the incentives of HEP. This 2 percent of a hospital's final dollar amount is paid into a "contingency fund" which is held and disbursed by RAHC. Any balance remaining in the fund at the conclusion of the experiment is shared equally by the hospitals and the payors and distributed among them in proportion to their contributions to the fund.

The sum of all the final dollar amounts of the individual hospitals is called the "final aggregate dollar amount." This is the maximum amount of net patient revenue that all the participant hospitals may share in a given year and is diagrammed in Exhibit 1.

Final allowable cost base

While the final dollar amount limits the amount the hospital system as a whole may receive, the final allowable cost base defines the revenue an individual hospital can receive for services to patients, since it is the base on which the liabilities of the contracting payors are established. It is also a cap on revenue because a hospital's total net patient revenue from all sources in excess of the final allowable cost base must be paid into the contingency fund. Any excess revenue thus accrues to the system as a whole and not to an individual hospital. This aspect of the final allowable cost base extends the revenue cap to *all* classes of payors not only the three contracting payors.

Calculation of the final allowable cost base, as of the final dollar amount, uses 1978 base year costs with adjustments for CON projects and is diagrammed in Exhibit 2. In 1979 and 1980 only, the hospital managers were provided a 1 percent increase over the trend factors for working capital. Hospitals' final allowable cost bases are also increased by payment for increases in service volumes according to contract formula.

A policy common to all prospective payment systems and used by all hospital rate-setting agencies is not to put hospital administrations at risk for cost increases beyond their control, for example, those associated with general economic inflation. The combinations of goods and services consumed by hospitals is different from that of other sectors of the economy. The effect of inflation on hospitals is not accurately reflected in the indexes developed by the Bureau of Labor Statistics (BLS) or other economic forecasters. In order to implement HEP, a system was developed called the "trend factor methodology" to measure more precisely the effect of inflation on hospital costs.

This methodology separates each HEP hospital's 1978 costs into 50 components. These include wages, benefit categories (FICA, medical insurance), food, medical supplies (blood products, drugs, X-ray film), depreciation on movable equipment, building and fixed equipment.

Each of these cost components is assigned a weight which is its percentage of total costs. A proxy is assigned to each of these weights which estimates the price movement in that cost component for a stated time period. Some of these proxies are involved in the computation of the Consumer Price Index (CPI) and other indexes published by BLS.

For example, the subcomponent of the CPI which measures increases in food prices is the proxy used for the food cost component. Proxies are specified in the HEP contract and are calculated or estimated by RAHC at given intervals each year.

The overall trend factor for each hospital is the sum of the products of the proxy multiplied by the weight for each cost component.

The HEP trend factor differs from the methodology in the prior payment formula in three ways. They include:

1) The HEP trend factor is hospital-specific. The weights used in the computations are those of an individual hospital as opposed to an average of many hospitals;
2) The proxy for depreciation on buildings and fixtures is the actual movement in this cost category from one year to the next. If a hos-

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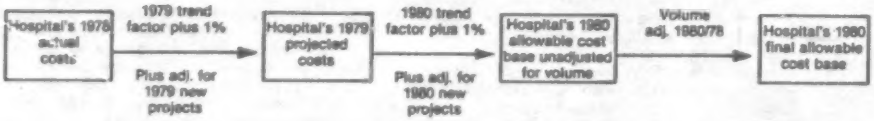
Exhibit 2: Computation of a hospital's 1980 final allowable cost base


Hospital's 1978 actual costs
1979 trend factor plus 1%
Plus adj. for 1979 new projects
Hospital's 1979 projected costs
1980 trend factor plus 1%
Plus adj. for 1980 new projects
Hospital's 1980 allowable cost base unadjusted for volume
Volume adj. 1980/78
Hospital's 1980 final allowable cost base

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pital's depreciation on building and fixed equipment increased 10 percent in 1980 over 1979, then the proxy used is 10 percent;

3) The proxy for wages and salaries (about 50 to 60 percent of a hospital's total costs) is related to the weighted average of actual salary increases given to production workers and working supervisors in the Rochester area. This ties the hospital's allowance for salary increases to the experience of the local labor market.

Apportionment of the allowable cost base

The allowable cost base defines the liabilities of the contracting payors. Distribution of the allowable cost base among the contracting payors is accomplished using standard Medicare apportionment techniques. Patient days by payor class is used to distribute routine costs. The ratio of charges-to-charges-applied-to-costs (RCCAC) is used to apportion ancillary and outpatient costs among contracting payors.

Under traditional New York State reimbursement, Blue Cross and Medicaid pay hospitals according to the average cost per day for all patients. This has led to shortfalls in revenue and cross-subsidization among payors. By applying the same system to all payors, this cross-subsidization should be eliminated under HEP. Payments to hospitals are made on a concurrent basis similar to Periodic Interim Payments (PIP) under Medicare. Interim payor liabilities are established using the latest audited apportionment statistics to calculate weekly payments.

It should be pointed out that the first year's influence on the change to the RCCAC methodology, the concurrent payments and the provision of the contingency fund had the effect of increasing Blue Cross' liabilities to the hospitals 6 to 7 percent over the trend factor. However, future increases in Blue Cross payments should be limited to approximately the trend factor.

The contingency fund

The hospitals' weekly payments include an amount for the HEP contingency fund equal to approximately 2 percent of the hospitals' allowable cost bases. It is used to pay hospitals for increases in volumes of services, CON projects, incremental operating expenses and various other purposes subject to the approval of the RAHC Board.

In 1980, the HEP contract restricted the use of the contingency fund to volume and CON adjustments. After 1980, the fund split equally into two sections: up to one-half for volume adjustment and CON expenses, and the balance for what is referred to as the "other" taps portion of the fund.

Each year's fund balance carries forward into the next year throughout HEP. Any unexpended monies remaining upon termination will be returned in equal parts to the hospital administrations and the contracting payors, proportionate to the original contributions to the fund.

Uses of the contingency fund—volume adjustment

The HEP contract volume adjustment formula was designed to provide hospital administrators with incentives. They are:

- Screen elective admissions to determine if they are medically required;
- To reduce length of stay;
- To replace, when medically appropriate, inpatient admissions with less costly outpatient modalities.

This is accomplished primarily by the method used to compute the inpatient volume adjustment. If admissions are less than in the base year (1978), its revenue is unaffected, enabling hospital managements to retain all inpatient revenues even though they are treating fewer inpatients. If a hospital experiences an increase in admissions over the base year, it must absorb the variable cost per admission of the first 2 percent increase. That is, the hospital will receive a volume adjustment for only those admissions beyond 102 percent of base year admissions. For admissions in excess of 102 percent, a hospital receives 40 percent of the base year's cost per admission (adjusted for inflation) from the contingency fund, which is a conservative estimate of variable costs.

Volume adjustment for outpatient services

For outpatient services, the intent of the volume adjustment will not reward or penalize a hospital for increases or decreases in the number of patients treated. Thus, there is no corridor for the outpatient volume adjustment. The adjustment may add to, or reduce, a hospital's revenue. For each added (or decreased) outpatient visit, lab test, X-ray procedure during the base year (adjustments are calculated departmentally), the hospital receives or contributes to the contingency fund an adjustment equal to 60 percent of the 1978 cost per unit adjusted for inflation.

RAHC review of all Certificate-of-Need projects is provided in its bylaws because of its goal of improving coordination of hospital planning. While RAHC's role is advisory to the Finger Lakes Health Systems Agency (FLHSA), the influence of RAHC review has been significantly strengthened since implementation of the HEP experiment due to the changes in new services' financing.

The HEP contract requires that the net incremental operating expenses of all CON-approved projects implemented after Jan. 1, 1980, be financed from the HEP contingency fund. After initial financing, these incremental expenses are added to the hospital's allowable cost base.

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Since all expenditures from the contingency fund must be approved by the RAHC board, the HEP contract has given added weight to local planning efforts. A hospital administration could, conceivably, receive state approval for a project rejected by RAHC. However, it would implement the project without certainty of adequate revenue for related increased operating expenses for the duration of the experiment.

The definition of the financial effect of CON projects is negotiated between RAHC and hospital staffs. The hospital submits an estimate of the cost effect of a project; RAHC staff reviews the assumptions underlying that estimate and resolves any issues with the hospital's staff. The final estimate is subjected to further analysis by committees and, ultimately, the RAHC board, where authorization to expend project-related contingency fund monies must occur prior to disbursements.

Three categories of costs are reviewed: 1) capital costs associated with buildings and fixtures, 2) capital costs associated with major movable equipment, and 3) incremental operating expenses. Depreciation and interest on buildings and fixed equipment is paid based on actual costs. For this reason, these projects are assessed on their merits in terms of community need. A simple review for reasonableness of financing and construction costs, relative to the scope of the project, is deemed sufficient.

Because HEP payment for depreciation on movable equipment results from trending forward this cost component from the base year, a hospital's revenue is fixed regardless of the addition of movable equipment. Because the administration is at risk for financing new equipment, only a cursory review of equipment costs occurs. Nonetheless, through the review of such applications by RAHC committees, opportunities for volume discounts (when several facilities are planning purchases of similar equipment) become apparent and can be pursued.

A more detailed review occurs for projects involving increased hospital operating expenses. Since the initial financing of these projects is from the contingency fund, it is RAHC's fiduciary responsibility to assure that these funds are spent appropriately. As a result, prior to presentation of an authorization request to the RAHC Board, such projects and their incremental costs are reviewed[9] to assure that project fiscal issues are raised and resolved. The RAHC board then votes on the project to authorize the payment for financing the project.

"Other" contingency fund taps

In 1981 and thereafter, one-half of the contingency fund may be used in connection with "other taps." These "other taps" were defined by criteria established by RAHC during 1980 to provide incentives for cost-effective resource management and may be applied to case mix adjustments, information system expenses, unforeseen events and oth-

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9. RAHC's review structure is extensive: The board of RAHC consists of two representatives from the boards of each member hospital and two representatives from the University of Rochester School of Medicine and Dentistry: typically, these representatives are past or present leaders within their institutions. The Medical Advisory Committee of RAHC consists of two members assigned by each hospital from its clinical management/medical staff structure; typical representatives might be the medical director of those hospitals having such positions coupled with a present or past president of the hospital's medical staff or a full-time chief of a clinical department. The Administration Committee consists of the chief executive officer of each member hospital. Additional board committees include the Finance Committee (each hospital board's Finance Committee chairman, headed by the treasurer of RAHC), the Executive Committee, and the Planning Committee. Other committees drawn from among hospital administrative personnel include the Fiscal Directors' Committee (each hospital's chief fiscal officer), the Operations Committee (each hospital's chief operating officer), the Planning Directors' Committee (each hospital's chief planner), and so on.

Rep. Barber B. Conable, Jr. (R-N.Y.) (far right), senior Republican on the House Ways and Means Committee, discusses the HEP program with (from left) Stephen Watts, board member, and William D. Ryan, board chairman; James A. Block, M.D., president, and Donna Regenstreif, Ph.D., vice president, RAHC.

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er situations as determined by the RAHC board. Currently, a portion of these funds is supporting development of a data base that will combine all hospitals' medical records, billings, and cost information. This data base should give hospital managers planning and management information not previously obtainable in a timely fashion on a community wide basis.

Also, a methodology is being developed to pay hospitals for changes in case complexity. This refers not only to case mix but also to changes in intensity and/or medical practice patterns.

Proposals submitted by participating hospital administrations, the university medical center, and others in the healthcare community, have been received and are being given funding consideration. These projects would analyze issues or support efforts to enable greater understanding of factors involved in success under HEP. Initial funding decisions are expected later this year.

First-year results under HEP

From a financial viewpoint, HEP was intended to accomplish two goals: 1) contain the rate of increase in hospital expenditures on a voluntary basis, and 2) restore solvency to a hospital system experiencing a rapidly deteriorating financial condition.

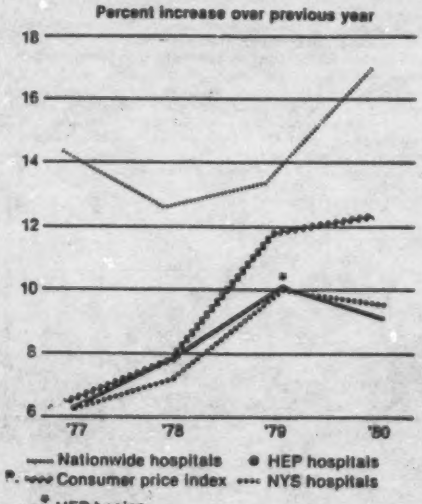
In 1980, the Rochester hospitals' collective increase in expenditures over 1979 was 9.1 percent. This compares favorably with expense movement under traditional reimbursement regulation elsewhere in the state and is in sharp contrast to the estimated 17 percent by which hospital expenditures expected to rise nationally during 1980, as shown in Exhibit 3.

The predictable revenues and reduced collection periods provided under HEP combined with the hospital administrators' efforts to contain costs have created the potential for Rochester area hospitals to generate capital to meet future requirements thereby better meeting the health needs of the community. Exhibit 4 presents some financial indicators demonstrating improvements under HEP.

Moreover, the hospitals' unrestricted cash increased by more than $10 million, nearly a 50 percent increase during the year. This favorable influence aided non-operating revenue and net income due to the high interest rates available in 1980 for short-term investments.

It is not expected that each subsequent year of the experiment will yield such dramatic positive changes. Nonetheless, since the hospitals' revenues are not predictable, hospital managers should be able to retain the first year's benefits and improve their financial condition further through prudent management during the duration of the experiment.

Exhibit 3: Hospital expense trends



Other management activities stimulated by HEP

Rochester area hospitals' progress under HEP in 1980 demonstrates that appropriate payment incentives can help hospitals improve their financial standing and contain their rate of cost increase. The "crisis" atmosphere surrounding management has been reduced and an environment of fiscal predictability prevails.

Hospital executives are beginning to seek solutions to some fundamental managerial and planning concerns. They now recognize that, implicit in the search for quality care at affordable cost, a new partnership is needed among all of the key players in the hospital field: administrators, medical staffs and governing boards.

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Exhibit 4: Hospital financial indicators

	HEP hospitals		Industry*
	1980	1979	average
Current ratio (current assets ÷ current liabilities)	1.53	1.36	1.90
Average collection period in days	40.5	52.5	59.4
Net operating margin (net operating income ÷ by operating revenue)	.012	(.01)	.023

*Industry averages per the Hospital Financial Management Association-Financial Analysis Service.

Planning must be guided by clinical forecasting because, in the course of caring for their patients, physicians hold the key to consumption of most hospital resources. Necessary services must be available within each hospital structure and as part of a community wide system. Governing bodies responsible both for quality of care and the hospital's level of financial performance need information which integrates clinical and financial data.

In anticipation of these needs, the HEP contract provided for the acquisition of a more complete set of financial, utilization, clinical and statistical information than ever has been available to a community's hospitals. Technical development to enable the production of routine management reports for each hospital administration to assist in its quality assurance, utilization review and budgeting functions has been completed. This year, hospital managers will receive the initial products of this merged clinical/fiscal data system based on 1980

Rochester's progressive healthcare community is acting as a laboratory for the nation in a significant cooperative reimbursement experiment . . . It may well provide a new direction in hospital financing. I can assure you it's being closely watched.

Rep. Barber B. Conable Jr.

experience. These reports will enable analysis of patterns of utilization and the medical practice patterns underlying demands for beds and support services. With these and other types of analyses as management tools, hospitals, physicians, and health planners can, for the first time, make management decisions which are directly based upon the hospital's patient care products and future projections of these.

In the years to come, major efforts will focus on further development of the data base and enhancements of the reporting capabilities. Other important ongoing RAHC activities include providing a forum for sharing emerging positive experiences to implement this new information, educational programs and technical assistance. Changes in undergraduate and graduate medical education curricula are expected as clinical knowledge becomes understood.

The 1980 results were assisted by various financially focused management reports called *"Financial Analyses."* These were completed for each participating hospital administration. Using comparable cost data from Maryland and RAHC hospitals, their purpose is to identify areas within a hospital with apparent potential for cost savings when compared to hospitals with similar characteristics.[h]

Hospital managers have been able to receive comparative reports through independent agencies or associations for some time. The major difference (other than methodology) between such reports and the RAHC financial analysis is the presentation process. Discussions occur (with the full cooperation of each hospital staff), after presentations to the RAHC board and finance committee, that enable each to learn and share the benefits of the information in a constructive, non-punitive atmosphere. An important goal is to focus hospital board members' understanding and attention on potential problem areas within an institution and to obtain the board's support for administration-initiated actions in follow-up.

Development of financial analyses has also aided in reviewing the budgets of the hospitals, provided for in RAHC's bylaws. The hospital administrations reached a consensus on budget review criteria such that, if a hospital facility did not meet one or more of the criteria, a detailed RAHC review of the hospital's budget would occur. The criteria selected included net patient revenue, expense movements and operating income tests. The detailed review was carried out using formats similar to the financial analysis.

However, instead of making comparisons with other hospital administrations, the hospital's 1978 costs (trended to 1981 levels) and the 1981 budget were compared. The purpose was to identify areas in which cost increases exceeded amounts allowed by HEP trend factors. Presentation of the budget reviews were done in the same context as the financial analyses, and were agreed to be of benefit to institutions in understanding the long-term effects of management decisions as well as factors outside of traditional direct management control, such as changes in case complexity or patterns of medical practice.

As a result of negotiations in the fall of 1980 (which led to the extension of the initial three-year term of the experiment to a five-year HEP), the extension contract was worded to provide for a mid-cycle review of the program's influence on payors and hospitals based upon five board criteria: rate of cost increase; hospital industry solvency; development and use of information system; effectiveness of hospital care; board and medical staff involvement. Clearly, all parties thus recognize the broader managerial implications of the program and are united in their determination to effect positive changes in these multiple sectors with the stimulus provided by positive incentives and predictable revenue under HEP. □

h. The Financial Analysis Methodology was developed cooperatively with hospital chief financial officers and is detailed in "RAHC Financial Analyses," Rochester Area Hospitals' Corporation, 1980.

Attachment C

RA
HC

Rochester Area
Hospitals' Corporation

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Questions and Answers about the Rochester Area Hospitals Experimental Payments Program (HEP)

1. What is the purpose of the *Rochester Area Hospitals Experimental Payments (HEP) Program?*
2. How will the HEP program lead to better health care at less cost?
3. Who developed the HEP program?
4. Was the Rochester Area Hospitals' Corporation developed exclusively for this purpose?
5. Which payors of hospital services are participating in the experiment?
6. In order for the experiment to be carried out, which parties had to agree to participate?
7. What features of the past hospital financing systems was the HEP program intended to improve upon?
8. What were the consequences of these payment systems for Rochester area hospitals?
9. How did the trustees of Rochester area hospitals try to rectify the situation which has been described?
10. What are the features of the HEP program?
11. Does the HEP program assure a meaningful limitation on the public's responsibility to pay for hospital costs increases?
12. What are the key features of the HEP program that enable it to control increases in hospital costs while maintaining an efficient, high-quality hospital care system?
13. How will HEP contribute to greater cooperation among hospitals?
14. What is the role of each hospital's board in the HEP Program?
15. What is the role of each hospital's administrative staff in the HEP program?
16. Why is HEP important to physicians as they make decisions about patient care?
17. How is the overall limit on yearly revenue for all hospitals determined?
18. How is the yearly revenue for each hospital determined?
19. What happens if total allowable costs of all the hospitals exceed the overall limit or cap on hospital revenues?
20. How will payments to hospitals be adjusted if they need to treat more patients or if they start new programs?
21. What happens if a hospital spends more caring for its patients in a year than it receives through HEP, even after all the appropriate adjustments are made for increases in numbers of patients and new approved programs?
22. How do the payors determine how much each pays into the revenue pool through the participating hospitals?

1. What is the purpose of the *Rochester Area Hospitals Experimental Payments (HEP) Program?*

The purpose of the HEP program is to demonstrate that the voluntary hospital system in the greater Rochester area can control the rate of increase in hospital costs and can maintain an efficient, high quality delivery system.

2. How will the HEP program lead to better health care at less cost?

This voluntary experimental payment program is based on positive incentives for changes rather than the punitive sanctions associated with existing cost containment efforts. It is designed to reduce excessive regulation and emphasizes local control and responsibility for our hospital system. As a result, planning and investment decisions can be made on the basis of the special needs of our patients and community, rather than on the basis of regulations which may be more applicable to other communities.

Under the HEP program, basic hospital operating revenues will be certain. This is in marked contrast to the unpredictable reimbursement climate which has characterized our hospital industry in recent years. This change will permit hospital managers and physicians to make the best use of scarce resources and facilities in response to the needs of their patients, free from the constraints of the traditional reimbursement system.

3. Who developed the HEP program?

The payment experiment was developed by the Rochester Area Hospitals' Corporation, whose board consists of two trustees of all Rochester area hospitals and the University of Rochester School of Medicine and Dentistry.

4. Was the Rochester Area Hospitals' Corporation developed exclusively for this purpose?

No. The Rochester Area Hospitals' Corporation, incorporated in July 1978, grew out of years of cooperative planning activities on the part of area hospital administrators, trustees, and physicians.

5. Which payors of hospital services are participating in the experiment?

The HEP program governs the payments of each of the major third party payors for hospital services—Medicare, Medicaid, and Blue Cross. In addition, the experiment includes the income for patient care services obtained by the hospitals for services rendered to patients who are not the beneficiaries of the major third parties. Hence, HEP covers, directly or indirectly, the payments for all inpatient and outpatient hospital services.

6. In order for the experiment to be carried out, which parties had to agree to participate?

Along with the Rochester Area Hospitals' Corporation and eight hospitals, the participation of the following parties was required in order for HEP to proceed.

- The State of New York, Department of Health, Office of Health Systems Management
- The State of New York, Department of Social Services
- Rochester Hospital Service Corporation ("Blue Cross")
- Health Care Financing Administration, (Medicare), U.S. Department of Health, Education and Welfare (After April 13, 1980: U.S. Department of Health and Human Services)

Needless to say, the implementation of the experiment required an enormous amount of effort, coordination, and good will on the part of all of the participants.

7. What features of the past hospital financing systems was the HEP program intended to improve upon?

Prior to January 1, 1980, the hospitals in the Rochester area were subject to three major payment systems and a wide variety of other forms of coverage. Medicare payments were governed by Federal regulations; Medicaid payments by State regulation; Blue Cross by a third set of regulations. The economic incentives in these systems were sometimes contradictory, did not permit hospitals to accurately predict their income, and invariably implied that a hospital's income would be reduced whenever the hospital reduced its costs. Each of these elements of the current reimbursement systems in corrected by HEP.

8. What were the consequences of these payment systems for Rochester area hospitals?

Because the economic incentives in these systems are sometimes contradictory, the hospitals often found it difficult to establish policies which could both enhance patient care and maintain hospital solvency. The variations in the systems from year to year limited the hospitals' ability to predict their income and hence to budget and plan effectively. As indicated above, hospital cost reductions were invariably accompanied by subsequent reductions in the hospital's income, hence cost improvements normally did not improve the hospitals' financial position. By 1978, these aspects of the then-current reimbursement system had combined to threaten the solvency of the hospital system in Rochester. In particular, the overall working capital position of Rochester hospitals was poor and some hospitals had been forced to liquidate a portion of their endowment funds to underwrite routine activities.

9. How did the trustees of Rochester area hospitals try to rectify the situation which has been described?

The hospital trustees joined together in a cooperative effort which led to the formation of RAHC and the development of a unique and imaginative reimbursement experiment. The purposes of the proposed system were two-fold. First, it was designed as a positive, voluntary response to the acknowledged problem of hospital costs containment. Second, it was intended to prevent any deterioration of the Rochester hospital industry by protecting it from insolvency.

10. What are the features of the HEP program?

The payment experiment involves a *prospective payment system* which provides economic incentives to individual hospitals to utilize their facilities and services in the most cost effective manner.

In particular, if a hospital is able to reduce its costs, it can share in the savings.

The prospective payment system provides greater certainty of hospital revenue. A hospital's guaranteed revenue in a particular year is determined by only four factors: (1) the hospital's revenue in the preceding year, (2) the reasonable impact of inflation on the costs of goods and services purchased by the hospital in providing patient care, (3) the number of patients treated, (4) the costs for new programs approved by the State.

Finally, HEP involves a waiver of most Federal and State reimbursement principles. As a result it reduces regulation in order to permit better management and to achieve and improve cost effectiveness.

11. Does the HEP program assure a meaningful limitation on the public's responsibility to pay for hospital costs increases?

Yes. In agreeing to participate in the experiment, the Rochester Area Hospitals' Corporation *and* the participating hospitals in the greater Rochester area have agreed to a limitation on the rate of increase in the amount of dollars to be made available for care in participating hospitals. This voluntary effort restricts increases in hospital income to the amounts in the proposed Cost Containment Act of 1979, a Federal initiative which was not adopted. In return for agreeing to an overall limitation on hospital revenue, the governance of the hospital system will rest with the local community.

12. What are the key features of the HEP program that enable it to control increases in hospital costs while maintaining an efficient, high-quality hospital care system?

Two reciprocal agreements embody the most important principles of the HEP program:

- HEP guarantees participating hospitals a specific revenue for five years beginning in 1980, by agreement with the three major payors (Medicare, Medicaid, and Blue Cross), which is sufficient to insure the solvency of the hospital industry.
- In return, the hospitals have agreed to accept this revenue amount as an overall limit for hospital expenditures.

Since hospital income is no longer based on incurred costs, if a hospital can improve efficiency while continuing to provide quality care it can apply the resulting savings to other purposes at the hospital board's discretion. The income might, for example, be held in reserve for future capital expansion, increased charity care, or other future purposes specified by the hospital board. Thus, this income may be used to underwrite a variety of improved patient care programs.

Also under HEP, a hospital no longer must deliver patient care in a specified setting in order to be reimbursed. This means that physicians will have greater discretion in the treatment of their patients.

As a result, increasingly efficient medical practice patterns can be developed. This situation represents an unprecedented opportunity for the development of alternative medical practice patterns which can improve patient care.

13. How will HEP contribute to greater cooperation among hospitals?

There are two primary incentives that will encourage cooperation among hospitals participating in HEP.

One of these is built into the procedure for approval of new projects that the hospitals want to initiate. All such requests are first routed to the HEP program for review and approval, before being submitted to the Health Systems Agency. Since the HEP program has a limited total dollar amount that can be applied for new projects by all hospitals combined, it must set priorities. And, since the reviewing body (the RAHC board) includes representatives of the boards of all participating hospitals, the review process insures that investment decisions will be made in the context of a community-wide definition of patient need.

The second incentive for cooperative action among hospitals is that, for the first time hospitals can make use of money saved through sharing facilities and programs with other institutions.

14. What is the role of each hospital's board in the HEP Program?

Participation in the HEP Program involved commitment to the purposes of the experiment by each hospital board. As already indicated, HEP intends to achieve its purposes through positive incentives, rather than through the types of sanctions that have attended traditional reimbursement systems. In order for a hospital to respond to these incentives, both administrative officers and physicians must understand them. Thus, the first role of each hospital's board is to insure that HEP's purposes and incentives are clearly understood by the hospital's administrative staff as well as attending physicians.

In order to respond to the incentives of HEP each hospital will also have to realize cost improvements. These cost improvements may be effected by improving the efficiency of hospital departments, by planning and reorganizing the

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delivery system, and by involving physicians in resource use analysis. To realize cost improvements intelligently, one needs information. Thus, a second role of each hospital's board is to become increasingly informed about those hospital functions in which costs improvements are possible. RAHC is in the process of developing a detailed data base to assist trustees in this effort.

In many instances, costs improvements will only be possible if the changes required to make them are firmly endorsed by the board of trustees. Hence, a third role of each hospital's board is to create an environment in which rational cost reductions and continued improvements in medical care delivery can be brought about.

15. What is the role of each hospital's administrative staff in the HEP program?

The cooperation of all hospital constituencies will be vital for HEP's success. A key role of the hospital chief executive officers, therefore, is to assure that the Board, medical staff, and personnel understand the purposes and opportunities for appropriate actions at all management levels.

In addition, HEP provides new opportunities for administrators to develop programs and management procedures that are more cost effective, without jeopardizing hospital income or quality of patient care. Each hospital chief executive will need to examine how best to take advantage of the incentives provided by HEP, within the individual hospital setting.

One of the most significant management tools that HEP will make available to hospitals is the extensive data base now being developed. This information will allow hospitals to monitor resource use to a degree that has never been possible before. This means that chief executive officers will need to work actively with physicians, to give them the assistance they need in analyzing practice patterns in the context of gaining the most effective use of limited resources.

16. Why is HEP important to physicians as they make decisions about patient care?

Increasing hospital costs have been a significant burden to patients, and have resulted in increasing regulation of the hospital industry as well as continued efforts to regulate and limit the discretion of physicians in the care of their patients. One of the basic objectives of HEP is to stem this growing web of regulations by demonstrating that we can, through voluntary effort, curtail the rate of increase in hospital costs.

The HEP program, through the agreements of the contracting payors, guarantees a certain amount of revenue to hospitals. Conversely, the hospitals have guaranteed to the payors and to the public that the revenue of Rochester area hospitals will be limited to this amount.

These agreements make it clear that the resource available to the industry are, on the one hand, limited; and on the other hand, definite. What is more, the amount of available revenue is *completely unrelated* to the setting in which hospital care is delivered.

To those among us who are physicians, this situation implies that we face a unique challenge. As a result of the flexibility inherent in the new hospital payment system, we will have greatly increased discretion to select the most appropriate setting and treatment modalities for the care of our patients, within a clearly defined amount of resources.

For HEP to be successful, alternatives to, and cost improvements in, inpatient care must be developed. These include, where *appropriate and feasible*, reductions in admissions and length of stays, a greater reliance on ambulatory settings, as well as a careful analysis of our use of ancillary services including laboratory testing, diagnostic radiology, pharmacy and medical supplies. If we can help curtail the rate of hospital cost increases, while providing excellent patient care, we will help forestall further regulation and erosion of our discretion over the care of our patients.

17. How is the overall limit on yearly revenue for all hospitals determined?

Each hospital's anticipated costs are projected, producing a "final dollar amount" of revenue needed for that hospital in a particular year. The figures for all hospitals are then added together to produce a total or "final aggregate dollar amount" of revenue needed for all participating hospitals for a particular year.

The formula for computing the final dollar amounts of revenue is based on actual costs from all hospitals in 1978. Inflation trend factors are added each year to the 1978 costs to account for price increases in the goods and services that hospitals use.

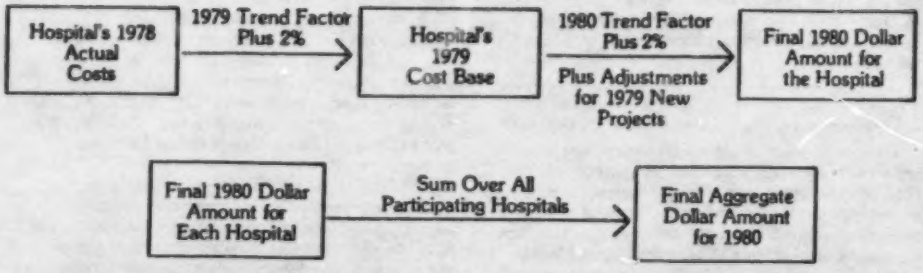
Also, two percent is added each year, to allow for increased hospital services to a growing, and aging, population in the Rochester area; to pay for new and improved medical technology; and to provide more working capital to participating hospitals.

The sum of all these costs, including the 1978 base costs, the inflation trend factors, and the special two-percent allowance for all participating hospitals, equals the upper limit on the revenue pool that all hospitals may share in a particular year.

The following diagram (A.) describes how the "final aggregate dollar amount" needed for all participating hospitals is computed.

Rochester Area Hospitals Experimental Payments Program

A. Computation of Maximum Allowable Hospital Revenue in 1980


Hospital's 1978 Actual Costs
1979 Trend Factor Plus 2%
Hospital's 1979 Cost Base
1980 Trend Factor Plus 2%
Plus Adjustments for 1979 New Projects
Final 1980 Dollar Amount for the Hospital
Final 1980 Dollar Amount for Each Hospital
Sum Over All Participating Hospitals
Final Aggregate Dollar Amount for 1980

18. How is the yearly revenue for each hospital determined?

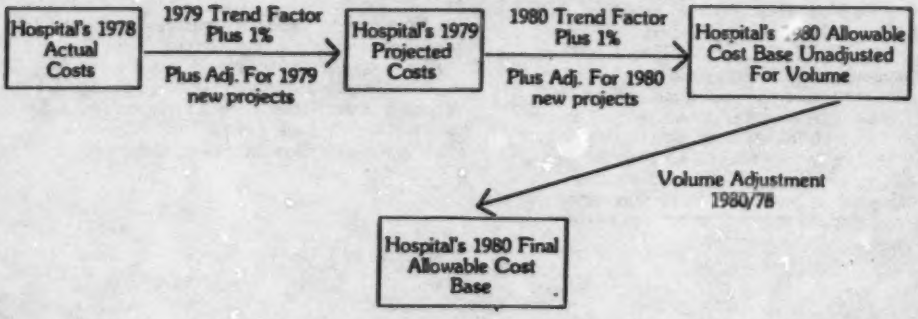
The amount of revenue a hospital will actually receive is based on its actual costs in 1978, plus inflation trend factors that have been computed for succeeding years, plus certain allowances. The allowances include one-percent increases for 1979 and 1980, to provide more working capital. (After 1980, no working capital provision will be made.) Additional allowances are made for changes in patient volume, and for new projects approved by the State Health Department.

The sum of all these factors, including 1978 base costs for the particular hospital, inflation trend factors, the one percent allowance through 1980, and allowances for change in work load and approved new projects, equals the revenues that a specific hospital may anticipate for a particular year.

The following diagram (B.) describes how a hospital's yearly revenue is computed.

Rochester Area Hospitals Experimental Payments Program

B. Computation of a Hospital's 1980 Final Allowance Cost Base


Hospital's 1978 Actual Costs
1979 Trend Factor Plus 1%
Plus Adj. For 1979 new projects
Hospital's 1979 Projected Costs
1980 Trend Factor Plus 1%
Plus Adj. For 1980 new projects
Hospital's 1980 Allowable Cost Base Unadjusted For Volume
Volume Adjustment 1980/78
Hospital's 1980 Final Allowable Cost Base

19. What happens if total allowable costs of all the hospitals exceed the overall limit or cap on hospital revenues?

This is unlikely because of the way the overall limit is computed, which allows for increased volume of service provided, as well as inflationary factors and new medical technology.

In the unlikely event that for some reason the cost bases of all hospitals added together did exceed the approved revenue pool, then the allowances for increased volume of services would be uniformly reduced to bring costs into line with revenues.

20. How will payments to hospitals be adjusted if they need to treat more patients or if they start new programs?

Adjustments for volume increases and operating funds for new programs approved by the State will come from a special fund set aside for this purpose by RAHC.

The source for this special fund is in the difference between the total amount of money provided by the third-party payors for hospital care, and the amounts actually allocated yearly for each hospital.

At the end of the three-year HEP Program, any money left in this special fund will be divided among the payors and the participating hospitals.

21. What happens if a hospital spends more caring for its patients in a year than it receives through HEP, even after all the appropriate adjustments are made for increases in numbers of patients and new approved programs?

This is not likely to happen for two reasons: first, hospital administrators for the first time have a guaranteed income base against which to plan for the year; and second, certain regulations have been waived under the HEP program. These changes give hospital chief executive officers much greater discretion over the management of their institutions, and greater opportunity to develop internal control systems for effective financial management.

If a hospital does spend more than it receives through HEP, it will be responsible for making up the difference.

22. How do the payors determine how much each pays into the revenue pool through the participating hospitals?

A detailed apportionment system developed by the Medicare program has been adopted for use by all payors in the HEP program. If the apportionment system determines that, for example, 35% of a hospital's costs are associated with serving Blue Cross beneficiaries, then Blue Cross will be responsible for providing 35% of the approved revenues for that hospital in that year.

Similarly, if patients not covered by the three major third-party payors account for 25% of a hospital's costs, then the hospital can set its charges so as to generate income equal to 25% of its allowable revenue.

The apportionment system also distinguishes between inpatient and outpatient service costs that are assigned to a specific payor. (New York State law prevents apportionment of hospital outpatient costs to Medicaid. This exception does not prevent apportionment of outpatient costs to other payors, however, and does not endanger the effectiveness of the payment experiment.)

Attachment D

Executive Summary

Is it realistic to hope that the Federal Government's plan to scrap burdensome regulations—in partnership with the best of free enterprise—can actually curb inflation? In one field—the inflation-prone hospital industry—the answer appears to be yes.

A group of hospitals in Rochester, N.Y., has developed a new prescription to control costs. After just one year, they're showing that it works:

In 1980, Rochester's hospital costs increased at about one-half the national rate—yet overall the participating hospitals operated in the black.

"It's an interesting speculation," notes a Rochester business leader, "that had the rest of the nation's hospitals performed as well, we would have saved $7 billion."

The Crisis That Sparked A Major Change

Rochester shares many of the problems of other older northeastern cities. Its nine non-profit hospitals serve a population of one million in a multi-county area.

By the mid 1970s many of these hospitals were already facing serious financial problems. New York State, in an effort to curb rising hospital costs statewide, imposed severe new limits on hospital reimbursements.

As one community leader put it: "Since most observers agreed that the Rochester hospitals were already operating efficiently, the state action wasn't cutting fat—it was cutting bone."

A New Approach

Faced with a major crisis, Rochester's business community and hospital and University leaders, with the support of several farsighted officials of local government and Blue Cross, the State Health Department and the Federal Health Care Financing Administration, hammered out a new approach.

Here's how it works:

Under the traditional "old" approach, hospitals are reimbursed for each incident of patient care they provide on the basis of costs or charges. Result: If they improve their efficiency or experience a decrease in volume, their income goes down . . . so there are no real incentives for efficiency.

In contrast, under the "new" approach in Rochester, the major insurers of hospital care—Blue Cross, Medicare, and Medicaid—guaranteed a specified amount of money each year, for five years, to the Rochester area hospitals, as a group. This community-wide revenue cap is calculated based on 1978 costs, with annual adjustments for inflation.

Just as important, a multitude of state and federal regulations that govern the hospital industry's reimbursement were waived for the same period.

In turn, the Rochester hospitals contracted to continue to provide quality health care under local community control, and to share any savings with the health care insurers within the specified level of reimbursement.

Incentives: Trading Negatives for Positives

In one stroke—as simple as it was radical—the Rochester community exchanged years of punitive regulations for positive incentives to manage its own hospital industry.

To create the administrative framework for this plan, the hospitals formalized their organization as a new corporation named RAHC: Rochester Area Hospitals' Corporation.

The simple-yet-radical reimbursement experiment carries its own acronym, HEP—which stands for Hospitals Experimental Payments Program. It became effective on January 1, 1980.

Results: Important Advantages

Even in the first year, the new approach offers obvious advantages over the old reimbursement system:

1. Overall, Rochester's hospitals are not losing money for the first time in years.
2. The limited rise in costs is striking when compared nationally, where overall hospital costs increased 70% faster than those in Rochester.
3. Incentives for improved management are introduced into the picture, as Rochester hospitals strive for efficiency to make the most of the finite pool of funds available.

An important facet in the implementation of this new approach is development of another unique resource: the most complete community-wide hospital data bank in the nation—an essential management tool in a competitive environment.

Under development is a growing bank of clinical data, which, when merged with the hospitals' financial information, will give physicians—as well as administrators—new management tools for effective use of the community's health resources on behalf of their patients.

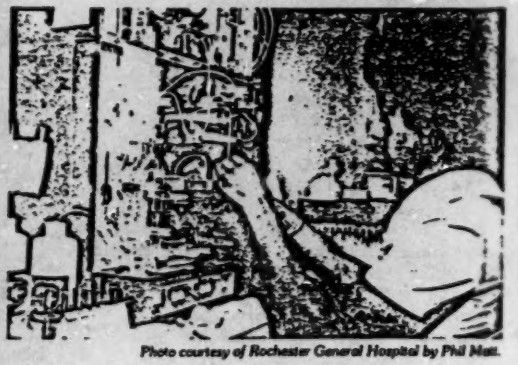


Photo courtesy of Rochester General Hospital by Phil Matt.

"Rochester's progressive health care community is acting as a laboratory for the nation in a significant cooperative reimbursement experiment . . . It may well provide a new direction in hospital financing. I can assure you it's being closely watched."

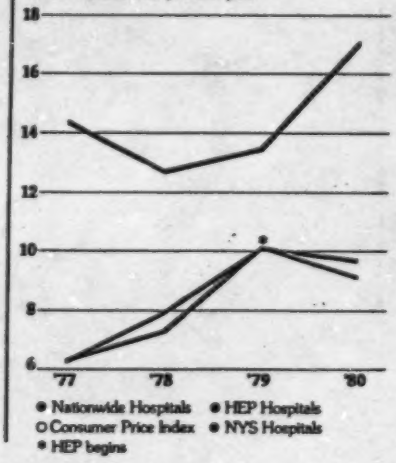
The national implications of Rochester's radical-yet-simple approach are reflected by this comment of Rep. Barber B. Conable, Jr., senior Republican on the House Ways and Means Committee and an authority on fiscal policy.

The Rochester Area Hospitals Experimental Payments Program: The First Year

In its first full year of operation, the HEP program appears to be fulfilling the promise that accompanied its formal launching on January 1, 1980. The rate of increase in hospital expenditures in Rochester was less than that achieved by the state or nation despite the total absence of punitive regulation to assist in enforcement of cost containment. Because of successful expense control, coupled with predictable revenue flows under the terms of HEP, hospitals were able to restore their cash position and add to the property, plant and equipment necessary to render effective patient care and maintain strong educational programs while achieving a reduction in long-term debt. It was an encouraging beginning.

Nationally, the picture remains far less pleasant. Costs of hospital care have risen alarmingly in recent years. Now approaching $100 billion yearly, they represent some 40 percent of the nation's total health care bill.

Hospital Expense Trends
Percent increase over previous year



According to Health Care Financing Administration estimates, hospital costs will climb to $335 billion in the next ten years.

HEP was developed in the late 1970s as the Rochester area's response to these pressures. Virtually all hospital-related interests were represented in the planning process. The hospitals and the University of Rochester created the Rochester Area Hospitals' Corporation. Through RAHC, they worked with private groups and local, State and Federal agencies including the New York State Departments of Health and Social Services, the Health Care Financing Administration of the U.S. Department of Health and Human Services, the national Blue Cross and Blue Shield Associations, the Hospital Association of New York State, the Finger Lakes Health Systems Agency, and the major insurers of hospital care: Medicare, Medicaid and Rochester Area Blue Cross. Grant support was obtained from the John A. Hartford Foundation of New York City.

The program they devised works this way: the major third-party payors contracted to pay hospitals specified revenues each year. The amounts are prospectively determined and paid according to a formula related to the proportion of hospital costs associated with caring for patients each payor insures.

The hospitals, in turn, agree to accept a specified limit on total revenue, thereby creating a community-wide revenue cap. Two percent of this revenue cap is paid by the hospitals each year to a contingency fund administered by RAHC. The contingency fund provides additional payments to hospitals that have increases in patient volume or initiate new approved projects or services. The contingency fund also supports special projects which promote cost-effective resource management. The participating hospitals voluntarily support the cost of RAHC activities, including the administration of HEP.

By the end of 1980, HEP's financial impact on participating hospitals was encouraging. The dual financial objectives of HEP appeared to be met: Rochester area hospitals not only were in the black, but were able to contain the rate of increase in expenditures while improving their financial condition and maintaining quality care.

Hospital Financial Indicators

	HEP Hospitals 1980	HEP Hospitals 1979	Industry Average
Current Ratio *Current Assets ÷ Current Liabilities*	1.53	1.36	2.30
Average Collection Period *Days*	40.5	52.5	60.8
Net Operating Margin *Net Operating Income ÷ Operating Revenue*	.012	(.01)	.040

"Rochester is acting as a laboratory for the nation in a significant cooperative reimbursement experiment," commented Rep. Barber B. Conable, Jr. (far right), senior Republican on the House Ways and Means Committee. Here, he discusses the program with (from left) Stephen Wolfe, board member, and William D. Ryan, board chairman; James A. Block, M.D., president, and Donna Regenstreif, Ph.D., vice president, RAHC.

Under HEP's voluntary cost containment program, hospitals in 1980 controlled expenditures even more successfully than in 1979, when they were still under the State's tight reimbursement regulations. Their rate of increase in expenditures dropped from 10.1 percent in 1979 to 9.1 percent in 1980. This is in sharp contrast to U.S. hospital cost figures, which rose an estimated 17 percent during 1980.

Although the statewide trend in hospital expenditures has paralleled the Rochester area's, the great majority of hospitals statewide have experienced a deteriorating financial condition. By contrast, the overall financial condition of the Rochester area hospitals improved in 1980.

The stable revenues provided under HEP, combined with hospital efforts to contain costs and a reduction in collection periods for receivables, have led to improvements in net margins. Liquidity has improved significantly: although it remains below industry standards, the hospitals' collective current ratio rose from 1.36 in 1979 to 1.53 in 1980. This is further evidenced by the significant improvement in the hospitals' cash position at the end of 1980 as shown in the Combined Statement of Changes in Cash Position for all HEP hospitals.

The combination of cost containment and revenue benefits described above is creating the potential for Rochester area hospitals to generate capital to meet future requirements, thereby better meeting the health needs of the community.

Hospital Utilization

	1980*	1979	1978
Admissions	104,263	107,013	105,354
Patient Days	835,692	841,697	827,356
Emergency Dept. Visits	208,048	207,931	206,631
Clinic Visits	336,788	316,320	300,969

**These data are preliminary and include estimates based on hospitals' submissions to RAHC.*

All HEP Hospitals
Combined Financial Statements
For the Calendar Years 1977 to 1980

Statement of Changes in Cash Position

Amounts in thousands	1980	1979	1978	1977
Cash from Operations:				
Operating Surplus (Deficit)	$ 3,339	$(1,307)	$ 656	$(3,232)
Charges to Operations not requiring a Cash Outlay (principally depreciation expense)	14,081	13,497	12,755	11,976
Total Cash from Operations	$17,420	$12,190	$13,411	$ 8,744
Other Sources/(Uses):				
Non-Operating Revenue (principally interest income)	$ 4,677	$ 1,784	$ 1,713	$ 718
Decrease/(Increase) in Net Current Assets, excluding Cash	3,178	5,850	(2,464)	494
Other	337	(691)	2,984	5,489
Total Cash Provided	$25,612	$19,133	$15,644	$15,445
Cash used for Capital Expenditures:				
Additions to Property, Plant & Equipment	$12,154	$ 8,133	$ 9,549	$14,723
Decrease/(Increase) in Long-Term Debt	3,440	2,453	3,124	(1,783)
Total Applications for Capital Purposes	$15,594	$10,586	$12,673	$12,940
Net Increase/(Decrease) in Cash	$10,018	$ 8,547	$ 2,971	$ 2,505

All HEP Hospitals
Combined Financial Statements
For the Calendar Years 1977 to 1980

Balance sheet

Amounts in thousands	1980	1979	1978	1977
Assets				
Cash and Securities	$ 30,250	$ 20,230	$ 11,683	$ 8,712
Other Current Assets (Principally Accounts Receivable)	38,590	44,566	49,766	46,714
Other Assets	9,259	7,771	5,549	4,865
Fixed Assets	204,156	206,111	211,688	214,899
Total Assets	$282,255	$278,678	$278,686	$275,190
Liabilities and Fund Balances				
Current Liabilities	$ 44,806	$ 47,604	$ 46,954	$ 46,366
Long Term Debt and Non-Current Liabilities	137,027	139,317	139,991	143,008
Total Liabilities	$181,833	$186,921	$186,945	$189,374
Fund Balance	100,422	91,757	91,741	85,816
Total Liabilities and Fund Balance	$282,255	$278,678	$278,686	$275,190

Statement of Revenue and Expenses

Amounts in thousands	1980	1979	1978	1977
Net Patient Revenue	$278,798	$251,695	$230,574	$209,427
Other Operating Revenue	8,651	7,407	6,617	6,599
Total Operating Revenue	$287,449	$259,102	$237,191	$216,026
Operating Expenses	284,110	260,409	236,535	219,258
Operating Surplus (Deficit)	3,339	(1,307)	656	(3,232)
Non-Operating Revenue	4,677	1,784	1,713	718
Net Surplus (Deficit)	$ 8,016	$ 477	$ 2,369	$ (2,514)

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Quality Care with Cost Control: Rochester area hospitals accept the challenge

The progress of Rochester area hospitals in 1980 under the HEP program clearly demonstrated that a prospective payment program can indeed help participating hospitals improve their financial standing. Crisis management has been reduced and an environment of fiscal predictability created.

As a result, hospitals in the Rochester area are now finding the "breathing space" to seek solutions to some fundamental managerial and planning concerns. In a nutshell, there has been an emerging recognition that, implicit in the quest for quality care at affordable cost, there is the need for an environment where true management is possible. And this, in turn, implies that physicians as well as administrators must participate on the management team, because in the course of caring for their patients, physicians hold the key to consumption of hospital resources. There is a growing awareness that financial management and clinical management are inseparable.

Photo courtesy of Rochester General Hospital.

The key role of the physician in cost management is increasingly recognized:

"The importance of involving physicians in the routine analysis of medical practice patterns and in understanding the impact of thousands of minute decisions on the patterns of care available to patients and the patterns of costs at hospitals is obvious. The plans for clinical analysis, which are currently evolving as a facet of the HEP program, should be of great interest to clinicians and policy makers throughout the country.

I believe that many other communities will have much to learn from the outcome of the Rochester demonstration program."

David E. Rogers, M.D., Ph.D., President, Robert Wood Johnson Foundation, Princeton, N.J.

During 1980 the hospitals, working through RAHC with the continuing assistance of the John A. Hartford Foundation, explored ways to help develop more integrated management processes. One of the first priorities has been to develop an information system that permits blending of financial and clinical information for management purposes.

The data base that serves as the primary information resource for HEP administration is one of the most complete hospital information systems in the United States. It was designed to include financial and utilization statistics, such as numbers of patient days, length of stay,

aggregate costs for various hospital functions, etc.; and also clinical information based on patients' medical record abstracts, billings and so on.

Systems are being developed to integrate and analyze these data so that patterns of medical practice can emerge and be associated with costs of treatment.

With these and other types of analyses as management tools, hospitals, physicians, and health care planners can now, for the first time, make management decisions based upon a more complete understanding of the hospitals' ultimate product—patient care—and how this product relates to community need for quality care at affordable cost.

James A. Block, M.D., President of RAHC, places these management needs in perspective: "The hospitals have recognized that new planning and managerial methods are required in order to define more precisely the 'product' of the hospital industry. This meant developing detailed financial and clinical analyses.

"Probably the most 'revolutionary' direction of our program is the emphasis on the daily role of the physician as the key determinant of hospital resource consumption and his or her long-term impact on the actual availability of equipment and services. That means physicians must become more active participants in the hospital management team, and they must have the appropriate support to perform that role."

Frank E. Young, M.D., Ph.D., Dean of the University of Rochester School of Medicine and Dentistry and Director of the Medical Center, notes that, "The development of the HEP experiment has added a new and important focus to our educational efforts, to include the analysis of health care practices and costs, an often neglected field in medical education and research. As this new information becomes available it must be incorporated into continuing medical education programs as well."

By obtaining and analyzing equivalent data from all participating hospitals, RAHC is able to create community-wide financial summaries and to make available specific information to each hospital about its own operations. These documents are intended to provide a framework for comparison and analysis of information to hospital administrators and physicians faced with management decisions. Since hospitals must, under HEP, realize all possible savings in order to operate within revenue limits, the additional information can help foster constructive competition without jeopardizing the community-wide planning process.

For example, after trustees of one Rochester hospital firmly declared their intent to maximize efficiencies under HEP, the community-wide comparative financial information from the data base helped them discover an opportunity to trim some $66,000 from the cost of malpractice insurance.

The need to understand and compare the "products" of the hospital industry is hardly new:

"We must formulate some method of hospital report showing as nearly as possible what are the results of the treatment obtained at different institutions . . . in a uniform manner so that comparison will be possible. With such a report as a starting-point, those interested can begin to ask questions as to management and efficiency."

From "The Product of a Hospital," by E. A. Codman, M.D., Boston; an address before the Philadelphia County Medical Society on May 14, 1913.

Planning and problem solving: RAHC provides the forum

In contrast to the usual planning hierarchy for localities, RAHC serves in concert with the Finger Lakes Health Systems Agency as a community discussion forum and planning umbrella for hospital system-related issues. The Health Systems Agency takes the lead in identifying the overall community need for hospital beds and services and then RAHC takes the lead in coordinating the development of the plans of its member hospitals to meet these needs.

This is a major responsibility. In carrying out its planning function, RAHC depends and builds upon the internal planning processes of the member hospitals. All hospital applications for new facilities or equipment requiring Certificate of Need (CON) approval from the New York State Department of Health are first reviewed at RAHC. This review is a multi-part process since it includes assessments of the clinical efficacy of the item, the current and anticipated need for it in the Rochester area, and the impact of the proposed service or equipment on the community's overall expenditures for hospital care.

To illustrate, Highland Hospital in 1979 requested approval to obtain a multi-crystal gamma camera and computer, a relatively new technology to evaluate more safely the extent of heart disease.

The application was discussed at length not only by the RAHC Board of Directors, but also by its Medical Advisory Committee, which is comprised of medical staff representing all hospitals; and by the Administration Committee, which includes chief executives of all hospitals. In addition, a meeting of community cardiologists and radiologists was called to discuss the new technology. When the application was approved, Highland was asked to report back in a specified time period with a summary of its experiences with the multi-crystal gamma camera, since it was the only such equipment in the area. This analysis will initially be shared with the Medical Advisory Committee, so that physicians representing RAHC member hospitals can be informed about the clinical outcome of such hospital investments.

Just as industrial managers are required to be specific about productivity objectives in a well-managed business, the CON application review process in RAHC thus encourages hospitals to become specific about clinical objectives and to use these objectives as checkpoints for management.

The value of the detailed clinical and financial planning data becoming available through RAHC is also underscored since the data will permit hospitals and planners to quantify clinical activity as never before.

During 1980 public discussions of several issues of major concern to the community's hospital system were coordinated through RAHC.

Open heart surgery

One of these was the recent growth in the demand for coronary artery bypass surgery and an associated lengthening of waiting time for patients referred for this procedure. In response the RAHC Board of Directors appointed an Open Heart Surgery Task Force, which included representatives of the RAHC member hospitals, the Monroe County Medical Society, Blue Cross, the Finger Lakes Health Systems Agency and the New York State Department of Health. The initial focus, on patient need, was addressed by a committee of cardiologists and cardiac surgeons from each community hospital affected, including the two open heart surgical facilities.

The Task Force studied the feasibility of expanding existing surgical capacities at Strong Memorial Hospital and Rochester General Hospital; explored the potential for establishing a third site for this type of surgery; and invited suggestions of other alternatives for meeting community need. The clinical committee was asked to review criteria for cardiac bypass surgery in Rochester and to develop projections of need through 1985.

After intensive study the Task Force was able to recommend specific measures to ease the immediate problem and to strengthen long-term planning for cardiac care needs in the community. Its report was published in the November, 1980, issue of the Monroe County Medical Society journal, *The Bulletin*. Its recommendations will be implemented during 1981.

A comment on the Open Heart Surgery Task Force:

"We should appreciate that . . . a major problem has been—— studied, analyzed, and in my opinion, solved. It was accomplished in record time, with speed and cooperation necessary to the urgency of the situation . . . We can now make the solution work by standing behind the recommendations, by implementing the recommendations, and by realizing that unless we do all that is required to achieve the goals, the problem will not be solved."

Thomas E. Cardillo, M.D., Executive Director of the Monroe County Medical Society and a member of the Open Heart Surgery Task Force, in *The Bulletin*, published by the Monroe County Medical Society, November, 1980.

The Task Force approach to an important and complex community problem was an effective model for future problem-solving efforts by RAHC.

Long-term care

Meeting the long-term care needs of patients at appropriate levels has been a continuing problem in the Rochester area as well as nationwide. For many interrelated reasons, such patients often remain longer than medically necessary in acute hospital beds, rather than being placed promptly in non-acute facilities or at home with support services. Not only is this situation difficult for the patient and family, but it results in costs that are disproportionate to the level of care needed, and in reduced availability of hospital beds for patients needing acute care. Since the supply of acute care beds is limited as a result of planning efforts, the backup of long-term patients in acute care facilities creates a serious drain on the hospital resources available to patients.

As more specific data emerged during 1980, both the scope of the problem and its negative impact on hospitals, physicians and patients became increasingly obvious. All of the hospitals have taken action to address the problem. At St. Mary's Hospital, for example, a study led to reorganization of several separate functions into a single department responsible for coordinating discharge plans. The number of patients at St. Mary's awaiting long-term placement dropped by some 60 percent, and the hospital has been able to devote more of its resources to acute care.

Centralized Services: The Regional Kidney Services Center

Implementation of the Regional Kidney Services Center was another 1980 milestone.

This is a self-care-oriented renal dialysis center, operated by the Regional Hospital Services, Inc., which is a subsidiary corporation of RAHC. The Kidney Center serves dialysis patients from throughout the region. Individualized patient training is an important part of the program. Greater self-management by dialysis patients permits lower staffing ratios and lower costs while at the same time benefiting patients who feel more control over their treatment.

Development of the Kidney Center has served as a good experience in planning for centralized services. Since the number of potential patients to be served in such a setting was relatively small, administrators of hospital-based dialysis units agreed it would be suitable from both economic and patient care viewpoints to create a single shared center for self-managed dialysis rather than expand each existing unit's capability in this area. A committee of the Medical Directors of the four hospital-based chronic dialysis centers provide advice and guidance on operation of the Kidney Center.

Access to care

An underlying assumption in the search for quality health care is its accessibility. Frequently this is understood to apply chiefly to patients: for example, that patients could be admitted promptly to hospitals when they need care. With this interpretation, factors such as the backup of long-term patients in acute beds reduce access to care because they block beds that acute patients need.

An additional interpretation of the concept of accessibility has been emerging, however, as the community grapples with the need to limit health care expenditures to affordable levels. This interpretation focuses on the opportunity for physicians to refer and follow their patients to needed clinical services. The question becomes particularly relevant as health care planning tends to limit the distribution of more highly specialized clinical services to one or two locations in the region. The question of centralized services, and of equitable access for physicians and patients, is expected to be an important topic in coming months.

Coming in 1981

Many activities initiated at RAHC and its member hospitals during the past year are continuing ones. Among them are solutions to the problems relating to long-term care, the issue of access to hospital facilities and services, further development of a methodology for accomplishing clinical analyses using the data base, and ongoing guidance of HEP.

A major new project for 1981 is preparation of a plan for a unique system for improving the integration of mental health services in Monroe and Livingston Counties. Funded by a $215,000 planning grant to RAHC from the New York State Office of Mental Health, the plan will propose ways in which these services can be coordinated and financed more effectively. As with the HEP program, the mental-health planning project is advised by committees representing the organizations that have major responsibility for operating and planning mental health services in the two counties.

As the events of 1980 demonstrate, the Rochester area health care community is taking positive, innovative steps at the local level to address issues that are fundamental to the continuation of a voluntary health system in America. It is obvious that many difficult obstacles must be overcome in the community's and the nation's search for affordable health care of high quality that is accessible to those who need it. Those participating in the cooperative community process to resolve these problems in the Rochester area are optimistic that success is possible.

Rochester Area Hospitals' Corporation
Balance Sheet
As of December 31, 1980 and 1979

Assets	1980	1979
Unrestricted Funds		
Cash and Temporary Investments	$ 161,599	$388,994
Accounts Receivable	24,588	85,554
Prepaid Insurance	1,966	924
Fixed Assets, at Cost, Less Accumulated Depreciation of $5,607 and $1,461	40,628	16,113
Total Unrestricted Assets	$ 228,781	$491,585
Restricted Funds		
MINICAP Contingency Fund		
Cash and Temporary Investments	$ 604,495	-0-
Due from Member Hospitals	-0-	548,925
	$ 604,495	$548,925
HEP Contingency Fund		
Cash and Temporary Investments	$3,570,715	-0-
Accrued Interest Receivable	54,782	-0-
Due from Member Hospitals	537,598	-0-
	$4,163,095	-0-
Liabilities and Fund Balances		
Unrestricted Funds		
Accounts Payable	$ 26,756	$119,598
Accrued Payroll and Payroll Taxes	14,710	-0-
Deferred Grant Income	185,818	388,970
Total Liabilities	$ 227,284	$508,568
Unrestricted Fund Balances		
Operating	(39,131)	(33,096)
Fixed Asset	40,628	16,113
Total Fund Balances	1,497	(16,983)
Total Unrestricted Liabilities and Fund Balances	$ 228,781	$491,585
Restricted Funds		
MINICAP Contingency Fund		
Fund Balance	$ 604,495	$548,925
	604,495	548,925
HEP Contingency Fund		
Fund Balance	4,163,095	-0-
	$4,163,095	-0-

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Rochester Area Hospitals' Corporation
Statements of Activity
For the Years Ended December 31, 1980 and 1979

	UNRESTRICTED				RESTRICTED		
	Operations & Fixed Assets	Grant Related	Total 1980	Total 1979	MINICAP 1980	MINICAP 1979	Hospitals Experimental Payments Program (HEP) 1980
Revenue and Support							
Dues from Member Hospitals	$328,096		$328,096	$282,833			
Grant Income		$353,152	353,152				
Interest Income	3,018	26,869	29,887				
Billing to Member Hospitals for 1978 Deficit				9,393			
Miscellaneous				518			
	$331,114	$380,021	$711,135	$292,744			
Expenses							
Salaries and Benefits	186,784	116,930	303,714	112,936			
Office Supplies and Expenses	61,494	35,899	97,393	59,499			
Consultants, Contracts and Data Processing	64,356	227,192	291,548	137,292			
	$312,634	$380,021	$692,655	$309,727			
Excess (Deficiency) of Revenue and Support Over Expenses	18,480	–0–	18,480	(16,983)			
Nonexpendable Additions							
Amounts Received and Receivable from Member Hospitals						$548,925	$3,957,705
Interest Earned					$55,570		205,390
Fund Balances (Deficit), Beginning	(16,983)		(16,983)	–0–	548,925	–0–	–0–
Fund Balances (Deficit), Ending	$ 1,497		$ 1,497	$ (16,983)	$604,495	$548,925	$4,163,095

NOTE: These financial statements are condensed and do not include all the details required by generally accepted accounting principles. However, the complete financial report for the year 1980 was audited by Metzger, Wood & Sokolski, Certified Public Accountants, and their unqualified report was issued March 19, 1981.

Executive Summary

For the second year in a row, the 10% increase in costs at hospitals in the Rochester, N.Y. area was just over *half* the 18.7% rate of increase experienced nationally. Elsewhere in New York State, where hospitals are subject to tight rate regulation, hospital cost increases exceeded those in Rochester. Yet the Rochester area's hospitals increased the volume of patient care they provided, enhanced a variety of clinical services, and operated in the black.

How was this accomplished?

The answer lies in a unique five-year demonstration called the Hospitals Experimental Payments (HEP) Program, under which all hospitals in the community are exposed to powerful new financial incentives to improve productivity, freed from the constraints of traditional reimbursement, and allowed to operate responsively under local management initiative.

Under HEP, the nine Rochester area hospitals as a group are guaranteed a predictable income from major insurers of hospital care—Blue Cross, Medicare and Medicaid—over a five year period, with adjustments to reflect the impact of inflation and changes in volume of patient care. Regulations that formerly hampered effective management, such as those which penalized efficient hospitals by reducing income when expenses were reduced, have been eliminated. In return, the hospitals have contracted to provide quality care while living within their community-wide revenue cap. Under the HEP agreement, contingency funds not required by the hospitals will be shared with the payors who advanced these funds.

Experience is demonstrating that the Rochester area hospital system under HEP is operating in the black and strengthening its financial and clinical capability to meet future needs—while maintaining its reputation for excellence in hospital care and medical education.

With the Reagan administration's emphasis on decentralized, non-regulatory approaches for reforming the inflation-prone health care industry, HEP is already drawing attention nationally as a promising model. Representatives of HEP's parent group, the Rochester Area Hospitals' Corp., have described HEP to the U.S. Senate Finance Committee's Sub-Committee on Health; health publications have noted its promising performance; a growing stream of inquiries and visitors reflects the interest of other localities and states; and continuation of support from The John A. Hartford Foundation of New York City similarly recognizes the potential of the Rochester experiment.

Newfound fiscal stability under HEP is freeing Rochester area hospitals to take a hard look at other tough questions—such as how many acute hospital beds the community needs, and where they should be located. The difficulty of these decisions is compounded by many factors, including:

- ☐ The back-up of long-term care patients in acute beds, a nationwide problem;
- ☐ Continuing rigidity in the long-term care reimbursement system, which hampers effective patient placement;
- ☐ An aging population, with corresponding changes in health care needs;
- ☐ A voter mandate to the federal government coupled with a shaky national economy that is forcing reexamination of all public priorities, including health care.

The process of tackling these difficult issues is providing a focal point for cooperation among leaders in health care, business, industry, government and the community at large, as they join the search for new and workable ways to meet the community's needs for hospital care.

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Black Ink on the Bottom Line: HEP's Second Year

During 1981 the nine hospitals participating in the Rochester Area Hospitals Experimental Payments (HEP) Program continued to improve their overall fiscal position. For the second consecutive year they operated within the voluntary community-wide cap on hospital expenditures established under HEP, while at the same time reporting positive operating and net margins.

The hospitals achieved this goal despite increased patient days coupled with declining admissions. This lengthening of hospital stays is believed to be related in part to the backup of long-term patients in acute hospital beds. Since in-patient revenues under HEP are related to numbers of patients admitted rather than to individual services provided or length of stay, hospitals are encouraged to seek the most cost-effective ways to provide necessary health care.

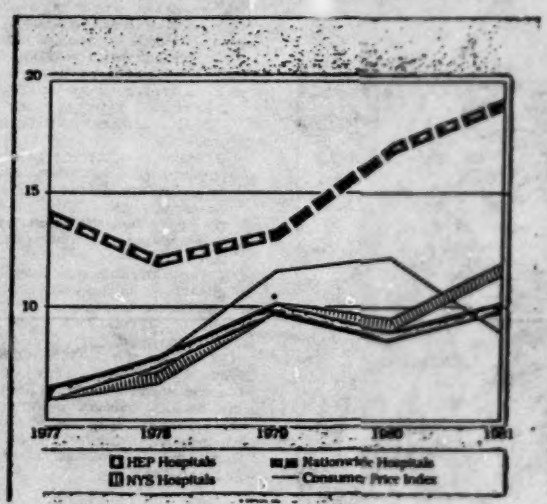
The year's results gave further support to a basic premise of HEP, which is that hospitals and their medical staffs can improve productivity and maintain better control over rising costs when they are assured predictable income and provided opportunities to respond to positive financial and planning incentives.

Hospital costs in the Rochester area rose 10%* during 1981, in comparison with a 12% rise in New York State, and 18.7% nationwide. The HEP hospitals' cost increase also compares favorably with the increase in the medical care component of the Consumer Price Index. While the CPI as a whole rose 8.9% in 1981, its medical care component rose 12.5%.

The improvement in the Rochester area hospitals' overall financial status is reflected by indicators of liquidity and cash position. Cash flow has been eased greatly by the prospective payment process under HEP, which has helped to reduce average collection periods for receivables to 34.6 days. This compares with an industry average of almost 60 days.

Although the 1981 net operating margin of .011 for the hospitals as a group remains below industry averages, this indictor shows significant improvement over its level prior to HEP. During the mid-1970s, Rochester area hospitals, like others in New York State, were under increasing fiscal pressure. As a group, RAHC hospitals showed operating losses in two of the three years preceding the start of HEP in 1980. Operating deficits were, and remain, a Statewide problem: one study** shows that nine of every 10 voluntary hospitals in the State operated in the red for at least two of the five years from 1974 to

HOSPITAL EXPENSE TRENDS
Percent increase over previous year



*The rate of increase for HEP hospitals in 1981 would be 10.7% if adjustments were made for certain changes in physician billing practices that would lower the 1980 cost base used for comparison. The unadjusted basis is used here because it is more directly comparable to State and National statistics.

**Schwartz, W.B., M.D.: "The Regulation Strategy for Controlling Hospital Costs." *New England Journal of Medicine* 1981; 305:1249-1255 (Nov. 19, 1981).

1978. One-fourth of the $2 billion equity of community hospitals Statewide had to be used to underwrite operating losses during the study period.

By helping to stem this erosion of equity, HEP supports the community's efforts to preserve a quality health system. Continuing progress toward fiscal stability will allow Rochester area hospitals to maintain and replace physical plants and equipment to meet growing or changing health care needs, and to remain competitive in the marketplace for top-caliber professional and support staff.

Service Improvements

With predictable revenues under HEP, the hospital system has expanded and improved a variety of clinical services during 1981. In doing so the hospitals have cooperated closely with State and local planning authorities in efforts to yield more rapid approval and implementation of needed new services and technologies.

In the area of cardiovascular diseases, for example, clinicians defined a need for an increase in the community's treatment capacity. Implementation of the recommended expansion had begun in 1980. During 1981 RAHC approved HEP funding for several proposals including expanded open heart surgical capacity at Strong Memorial Hospital and Rochester General Hospital, an outpatient rehabilitation program for cardiac patients at St. Mary's Hospital, and new cardiac monitoring equipment at The Genesee Hospital. During review of its application, Genesee agreed to share its evaluation of this new equipment with the RAHC Medical Advisory Committee, so that patients and physicians at other hospitals could benefit from its experience.

Hospital services and support staff were also strengthened in other ways during 1981, including expansion of the community's ambulatory surgery capacity and implementation of a variety of other programs and services. Since all hospital care must be provided within the community cap on revenues established under HEP, cost impact is an important consideration in planning for any additional services. In some cases hospitals have found that services designed to improve care can also reduce costs. One illustration is a nutrition support service initiated at Strong Memorial Hospital during 1981 to improve nutrition of patients requiring intravenous or tube feeding. This service has improved patient care, decreased costs of formula preparation and feeding equipment, and identified more patients who could be tube-fed as a substitute for the more costly intravenous feeding. A study is now being conducted to determine the relationship between improved nutrition and length of hospitalization.

Funding for Changing Needs

The Contingency Fund set aside each year under the HEP program is used in part to help hospitals adjust to changes in patient volume occurring as the year progresses.

The Contingency Fund also provides operating revenues for approved Certificate of Need projects. During 1981 these included the cardiac surgery expansions at Strong Memorial and Rochester General Hospitals; and establishment of an out-patient mental health facility at Noyes Memorial Hospital in Livingston County. The Noyes mental health project will draw psychiatric staff from The Genesee Hospital in Rochester, thereby extending a specialized service into a predominantly rural area.

Another major purpose of the Contingency Fund is to support special projects that are consistent with the goals of HEP. For example, during 1981 several hospitals received funding for Geriatric Assessment Teams aimed at

Hospital Utilization

	1981*	1980	1979	1978
Admissions	99,492	104,263	107,013	105,354
Patient days	845,704	835,892	841,997	837,356
Emergency dept. visits	197,201	208,048	207,831	206,631
Clinic visits	336,903	336,788	316,320	300,980

Hospital Financial Indicators

	HEP Hospitals			Industry average
	1981*	1980	1979	
Current Ratio *Current assets ÷ current liabilities*	2.33	1.53	1.36	1.89
Average Collection Period *Net days in A/R*	34.6	40.5	52.5	59.2
Net Operating Margin *Net operating income ÷ operating revenue*	.011	.012	(.01)	.022

**These data are preliminary and include estimates based on hospitals' submissions to RAHC.*

All HEP Hospitals
Combined Financial Statements

For the Calendar Years 1978 to 1981*
Amounts in thousands

improved management of patients who need both acute and chronic care. Another group of special projects receiving Contingency Fund support during 1981 will help hospitals to integrate HEP incentives into their management structures and learn to use new information that is becoming available through the community-wide data base. The integrated clinical and financial formats yield data on the interrelationship between clinical decisions and hospitals' resource allocations. Analysis of this information will enable better understanding of the effectiveness of patient care.

As HEP enters its third year, Rochester area hospitals continue to benefit from a stable revenue base that provides a rational environment for long-term planning and exploration of options for community service.

Statement of Changes in Cash Position

	1981	1980	1979	1978
Cash from Operations:				
Operating Surplus (Deficit)	$ 3,578	$ 3,339	$ (1,307)	$ 656
Charges to Operations not requiring a Cash Outlay (principally depreciation expense)	14,968	14,081	13,497	12,755
Total Cash from Operations	$ 18,546	$ 17,420	$ 12,190	$ 13,411
Other Sources/(Uses):				
Non-Operating Revenue (principally interest income)	$ 7,316	$ 4,677	$ 1,784	$ 1,713
Decrease/(Increase) in Net Current Assets, excluding Cash	(11,630)	3,178	5,850	(2,464)
Other	13,351	337	(691)	2,984
Total Cash Provided	$ 27,583	$ 25,612	$ 19,133	$ 15,644
Cash used for Capital Expenditures:				
Additions to Property, Plant & Equipment	$ 17,077	$ 12,154	$ 8,132	$ 9,549
Decrease/(Increase) in Long-Term Debt	3,262	3,440	2,453	3,124
Total Applications for Capital Purposes	$ 20,339	$ 15,594	$ 10,586	$ 12,673
Net Increase/(Decrease) in Cash	$ 7,244	$ 10,018	$ 8,547	$ 2,971

**For purposes of comparison, Monroe Community Hospital, which began to participate in HEP in 1981, is not included in these tables.*

Balance sheets

	1981	1980	1979	1978
ASSETS				
Cash and Securities	$ 37,494	$ 30,250	$ 20,230	$ 11,683
Other Current Assets (principally accounts receivable)	37,897	38,500	44,566	49,706
Other Assets	11,241	9,259	7,771	5,549
Fixed Assets	206,193	204,158	206,111	211,688
Total Assets	$292,625	$282,255	$278,678	$278,686
LIABILITIES AND FUND BALANCES				
Current Liabilities	$ 32,283	$ 44,806	$ 47,604	$ 46,954
Long Term Debt and Non-Current Liabilities	134,444	137,027	139,317	139,991
Total Liabilities	$166,727	$181,833	$186,921	$186,945
Fund Balance	125,898	100,422	91,757	91,741
Total Liabilities and Fund Balance	$292,625	$282,255	$278,678	$278,686

Statement of Revenue and Expenses

	1981	1980	1979	1978
Net Patient Revenue	$307,045	$278,798	$251,685	$230,574
Other Operating Revenue	9,238	8,651	7,407	6,617
Total Operating Revenue	$316,283	$287,449	$259,102	$237,191
Total Operating Expenses	$312,705	$284,110	$260,409	$236,535
Operating Surplus (Deficit)	3,578	3,339	(1,307)	656
Non-Operating Revenue	7,316	4,677	1,784	1,713
Net Surplus (Deficit)	$ 10,894	$ 8,016	$ 477	$ 2,369

includes a review of the State's methodology and preparation of recommendations as to where these beds might best be located. Ultimately these recommendations, when approved by RAHC and its member hospitals, will be submitted to the FLHSA for review and incorporation in their Health Systems Plan which serves as a frame of reference for Certificate of Need applications.

It is indicative of RAHC members' commitment to the planning process that three hospital applications for additional acute beds were voluntarily tabled during 1981, pending completion of the Plan's recommendations in mid-1982.

Although the recommendations of the Community Hospital Plan will be far-reaching indeed, they do not represent an effort to redesign the hospital system. Rather, they are intended to produce a sharper focus on desired future directions for the existing system.

Information: A Vital Resource

Availability of information from the community-wide hospital data base has been a vital advantage for RAHC and its member hospitals in many aspects of their work. As one of the most extensive sources of hospital information in the nation, the data base includes financial data, utilization statistics, and clinical information.

One purpose of the data base has been to facilitate the financial administration of HEP. It is also a cornerstone of the development process for the Community Hospital Plan. One of the most promising applications of the data base, however, lies in its role as the foundation of an information and reporting system that will ultimately provide hospital boards, chief executive officers and medical staffs with reports on the type and volume of clinical "products" that the hospital produces, and the patterns of cost and resource use associated with them.

Important steps toward development of this type of integrated information system were taken during 1981. RAHC developed a capability to provide each of its member hospitals with two basic documents: a financial analysis of the hospital's own unit costs and staffing levels during 1980 compared with 1978 and compared to the experience of similar hospitals in Rochester or elsewhere; and a clinical analysis focusing on patients' length of stay at that hospital compared with similar data from Rochester area hospitals collectively, and from a group of similar hospitals elsewhere. The clinical analyses are currently being enlarged to include data on usage of ancillary services such as laboratory, x-ray, medical supplies, etc. Eventually the clinical and financial analyses will be merged into an integrated information system aimed at helping hospital managers, boards and medical staffs make better resource allocation decisions for their patients and institutions.

The ability of the data system to associate patterns of care with costs underscores the importance of physician involvement in hospital management—since physician decisions determine most hospital resource use. The implications carry over into medical education as well, as it becomes more clearly understood that health care professionals require training to respond to new opportunities for combining managerial and treatment skills.

Since information of the caliber provided by the community data base has never before been available, institutional management and information systems are being modified in order to use the new data to maximum advantage. Several hospitals have applied for HEP Contingency Fund assistance in integrating this new resource into their management structures.

Mental Health

RAHC's skills in community-wide approaches to hospital service delivery and finance are now being applied to the mental health field. During 1981 work was begun on the Monroe-Livingston County Single Service System Demonstration Project, one of three being funded by the New York State Office of Mental Health. The purpose of the three-year project is to develop a more comprehensive mental health service system in the two counties, by improvements in coordination and financing.

During its first year the existing system of mental health services was reviewed and possible models for an integrated system were identified. The model being proposed will be based upon a federation of providers that would include agencies receiving state and local mental health funds. These agencies would thus be joined in a common commitment to providing care to the community at risk, particularly the chronically mentally ill. The integrated system would help provide a focal point for coordination of mental health services, would include new payment incentives for cost-effective care, and would develop a community-wide data base to assist participating providers and agencies.

Coming in 1982

In the coming year RAHC will continue to work with other agencies, providers and payors to improve the community's ability to serve patients requiring long-term care. An important focal point will be the proposed capitation reimbursement system for hospitalized patients needing long-term care. By establishing rates which recognize varying disability characteristics of individual patients, the proposed system would enable long-term care providers to accept a larger proportion of heavy-care patients without undue risk of financial loss.

A continuing theme through virtually all RAHC activities and planning for 1982 and beyond relates to recognition by hospitals and medical staffs of their roles not only as providers of acute care, but also as part of a continuum of health care services required by the community. Awareness of this larger responsibility is growing on many fronts as RAHC joins in the search for long-term care solutions, in the development of a Community Hospital Plan, and in the evolution of a more effective management system to provide hospital care that the community can afford.

Rochester Area Hospitals' Corporation
Balance Sheets
As of December 31, 1981 and 1980

	1981	1980
ASSETS		
Unrestricted Funds		
Cash and Temporary Investments	$ 24,132	$ 161,599
Due from Restricted Fund	23,808	
Accounts Receivable	1,043	24,569
Prepaid Expense	15,636	1,986
Fixed Assets, at Cost, Less Accumulated Depreciation of $13,858 and $5,607	65,747	40,628
Total Unrestricted Assets	130,366	228,781
Restricted Funds		
Minicap Contingency Fund Cash and Temporary Investments		$ 604,495
HEP Contingency Fund		
Cash and Temporary Investments	$5,283,752	$3,625,497
Due from Member Hospitals	1,109,064	537,598
Loan Receivable from Subsidiary	127,800	
	$6,520,616	$4,163,095
LIABILITIES AND FUND BALANCES		
Unrestricted Funds		
Accounts Payable	$ 102,053	$ 26,756
Accrued Payroll and Payroll Taxes	53,612	14,710
Deferred Grant Income	15,343	185,818
Total Liabilities	171,008	227,284
Unrestricted Fund Balances (Deficits)		
Operating	(106,389)	(39,131)
Fixed Asset	65,747	40,628
	(40,642)	1,497
Total Unrestricted Liabilities and Fund Balances	$ 130,366	$ 228,781
Restricted Funds		
Minicap Contingency Fund Balance		$ 604,495
HEP Contingency Fund		
Due to Unrestricted Fund	$ 23,808	
Fund Balance	6,496,808	$4,163,095
	$6,520,616	$4,163,095

Rochester Area Hospitals' Corporation
Statements of Activity
For the Years Ended December 31, 1981 and 1980

	UNRESTRICTED FUNDS						RESTRICTED FUNDS			
	Operations and Fixed Assets	Data Base & Clinical Analysis	John A. Hartford Foundation Grant	OMH Grant Single Service System	Total 1981	Total 1980	Minicap 1981	Minicap 1980	HEP 1981	HEP 1980
Revenue and Support										
Dues from Member Hospitals	$360,000				$ 360,000	$328,096				
Grant Income			$176,756	$208,789	385,545	353,152				
Interest Income	16,545				16,545	29,887				
	376,545		176,756	208,789	762,090	711,135				
Expenses										
Salaries and Benefits	251,273	$158,260	88,995	95,003	593,531	303,714				
Office Supplies and Expenses	76,335	33,405	16,047	21,769	147,556	97,393				
Consulting and Other Professional Fees	133,347	222,143	71,714	88,232	515,436	291,548				
	460,955	413,808	176,756	205,004	1,256,523	692,655				
Excess (Deficiency) of Revenue and Support Over Expenses	($84,410)	($413,808)		3,785	($494,433)	18,480				
Capital Additions (Expenditures)										
Amounts Received and Receivable from Member Hospitals							$ 21,853		$4,415,401	$3,957,705
Interest Earned							60,947	$ 55,570	828,481	205,360
Contingency Fund Disbursements							(687,295)		(2,457,873)	
Fund Balances (Deficit), Beginning	1,497				1,497	($16,983)	804,495	548,925	4,163,095	
Transfers										
Fixed Asset Acquisitions	3,785			($3,785)						
Board-designated Transfers	38,486	413,808			452,294				($452,294)	
Fund Balances (Deficit), Ending	$ (40,642)				$ (40,642)	$ 1,497		$804,495	$6,496,808	$4,163,095

The preceding summary data were extracted from the audited financial statements of Rochester Area Hospitals' Corporation for the years ended December 31, 1981 and 1980. A copy of the complete financial statements and the independent auditors' report thereon may be inspected at the offices of the Corporation upon request.

THE UNIVERSITY OF ROCHESTER
MEDICAL CENTER
SCHOOL OF MEDICINE AND DENTISTRY · SCHOOL OF NURSING
STRONG MEMORIAL HOSPITAL

SMH DIRECTORS' OFFICE
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ROCHESTER, NEW YORK 14642
AREA CODE 716 275-4605

Gennaro J. Vasile, Ph.D.
Executive Director
Strong Memorial Hospital

August 10, 1982

Mr. Robert E. Lighthizer
Chief Counsel
Committee on Finance
Room 2227
Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Lighthizer:

This letter provides responses to the two questions conveyed by Senator Durenberger arising from my June 23, 1982 testimony before the Subcommittee on Health. The questions and related responses are provided below.

Question #1: "Under the Rochester Area Program, hospitals retain the difference between revenues and expenses. How many of the nine member hospitals have been able to to recognize a 'profit'?"

Response #1: The Rochester Area Hospitals Experimental Payments (HEP) Program has been in operation for two and one-half years. The question pertains to the financial results under the HEP Program for each of the nine participating hospitals for calendar years 1980 and 1981. In 1980, eight of the nine participating hospitals achieved bottom line surpluses ("profits"). The aggregrate excess of revenue over expense for these hospitals amounted to $8,016,000 or a 2.8% margin. The one hospital that sustained a bottom line loss did so because of an extraordinary expense adjustment. In 1981, all nine participating hospitals achieved bottom line surpluses ("profits"). The aggregrate excess of revenue over expense amounted to $12,600,000 or a 4.0% margin.

A major factor contributing to these results is the prospective nature of the reimbursement system's design that results in improved cash flow. This, coupled with successful cost containment efforts of the hospitals (stimulated by additional incentives of the Program), permits short-term cash investments which have been yielding interest income in excess of interest expense.

Question #2: "Do you believe that either the New York State or the voluntary Rochester area program could be implemented on the Federal level?"

Response #2: This is a question which requires a three part response because the New York State program is in a state of flux between its current program and a reform program which would address many of the former's deficiencies.

On June 23, I testified before the Subcommittee concerning the devasting impact of New York State's current reimbursement program on the financial health of the State's hospitals. What I did not indicate was that the system does not provide positive incentives (such as those found in the Rochester program) for the hospitals of New York State to contain costs or utilize limited resources most effectively. The design of the current State program fosters the most expensive use of resources -- inpatient -- by reimbursing on a patient day basis. Yes, there are offsetting design features such as group averaging, ceilings, and penalty provisions. However, these result in charges of arbitrariness and in appeals that take months and years to adjudicate in addition to being costly.

While it may be possible to implement New York's current program at the Federal level, especially if the grouping of hospitals feature can be applied to smaller states, I do not believe, based on the program's design and the experience of New York State hospitals that such a decision would reflect prudent long-term public policy. The program would result in short-term cost containment but, as a consequence, erode the financial viability of the nation's hospitals and, thus, their long-term ability to provide needed health services to the American public.

Concerns, such as the above, have led New York State to consider other alternatives. Legislation has been enacted (Spring 1982) to reform the current inpatient method of reimbursing the State's hospitals. A waiver to include the Medicare Program is also being sought from the Health Care Financing Administration (HCFA). The reform program for New York State would have many of the same design features as the Rochester Program (e.g., revenue cap and positive incentives) but would require mandatory participation, administration by the State, and incorporation of the grouping methodology. While I have reservations about the program (administration by New York State government and the grouping methodology), I believe the waiver being considered by HCFA should be approved. Without the waiver, New York's reform program cannot be fully evaluated for its potential application on a national basis.

The Rochester Program (HEP) does have a Medicare waiver, covers all payors, is voluntary and is administered privately without burdensome regulations and questionable grouping methodologies. Moreover, the Program has been highly successful in containing costs to levels significantly below national and State rates of increase. For these reasons, several of the design factors of HEP could and probably should be incorporated into a national program. The features include the following:

- Voluntary participation of hospital providers
- A revenue cap approach that covers all hospital costs and, therefore, all payors
- A single methodology for computing the prospective revenue cap (i.e., it should be prospective)
- General and specific incentives that promote improvements in productivity and the use of less costly but effective alternatives to inpatient utilization
- A simple and equitable methodology for computing the final settlement based on the proportion of use by various payors -- RCCAC - ratio of cost to charge applied to charges.
- Provision of an annual contingency fund from the revenue cap (2 - 4%) for:
  - Volume adjustments which are linked to incentives for the use of less costly alternatives to inpatient use.
  - Incremental operating expenses associated with certificate of need applications
  - Expenses, pre-approved, for special projects related to improving the effective and efficient delivery of hospital services
  - Expenses associated with developing and maintaining the relevant integrated clinical and financial data basis necessary for monitoring and promoting cost effective clinical practice
- Administration at the local level by an independent private sector agency with a proven capacity for effective community-wide planning and problem-solving for hospitals.

A legitimate argument could be made that Rochester and its historical leadership experience provided a fertile environment for the program's success, which is not typical of most American communities. In other words, the generic design features discussed above might not yield the same results in another state or community. I maintain that the program has worked in Rochester because the community wanted it to work and has labored hard and long to make it successful. The voluntary feature of the program should be preserved if it is to become a Federal program. The current Medicare/Medicaid program should be maintained and a HEP-like alternative offered to those states and communities willing to participate in a voluntary program to contain costs while providing needed health services. In Rochester we have guaranteed the payors that our hospitals will not exceed the community-wide, equitably-determined cap. After two full years we have been able to live up to that commitment. What I am suggesting is that our states and communities should be provided an opportunity to make and live up to similar commitments.

The thought of maintaining two programs (current Medicare/Medicaid and HEP-like programs) seems overwhelming. I have not thought through the intricacies or the potential problems. I am sure there are plenty of both. I would be pleased to give this more thought if such were deemed appropriate.

If any of the above requires clarification or further amplification, please feel free to call (716-275-4605) or write.

Sincerely,

Gennaro J. Vasile, Ph.D.
Executive Director
Strong Memorial Hospital

GJV:vlb

dictated but signed in Dr. Vasile's absence

Senator DURENBERGER. Now we will go to the public regulators. Mr. Crane?

Thank you very much for your patience.

STATEMENT OF MR. ROBERT M. CRANE, DIRECTOR, OFFICE OF HEALTH SYSTEMS MANAGEMENT, STATE OF NEW YORK, ALBANY, N.Y.

Mr. CRANE. Thank you, Mr. Chairman.

I am Robert Crane, director of the New York State Office of Health Systems Management. The Office of Health Systems Management is the component of the State health department that has responsibility for health-care regulation. And, as other speakers, I would like to try to summarize my remarks and ask that the full text be included in the record.

Senator DURENBERGER. Yes. Your full statement will be made part of the record.

Mr. CRANE. I think that New York State offers a good learning experience for the committee; in many respects, New York is a microcosm of the Nation. We have 20-bed hospitals, we have 1,000-bed teaching hospitals. If one looks at the major indicators comparing hospitals, I think you will find a great deal of commonality between New York State in the Nation.

Second, I think that, as you have heard from a number of speakers, there is little doubt that New York State's system of cost containment has been effective in containing costs—in the years 1975 through 1979 nearly halving the rate of increase compared to the Nation.

I think it is important to build on some of the things which other speakers have noted, that ratesetting alone is not adequate to do the job.

We see a tripartite program in New York State as being necessary for effective cost containment, one which builds upon a prospective reimbursement system, one that includes effective health planning, and one which includes effective utilization control. And, like the legs of a stool, those three parts are necessary, in our view, in order for the program or the stool to be functional.

Let me briefly highlight the key elements of New York's program: It is a prospective formula-based reimbursement system as opposed to budget-based systems in other States. A formula-based system in New York State was viewed as a necessity given the large number of facilities—close to 300 acute-care hospitals within the system.

The State saw the best way to measure efficiency within hospitals was to compare them, and so the State system includes a peer-grouping methodology which looks at such factors as teaching status, age of patients and case mix, and groups like hospitals together. Then we set efficiency standards for those groupings: A routine standard, which is applied on a per diem basis; an ancillary standard, which is applied on a per-discharge basis.

The system includes minimum-occupancy standards in order to encourage hospitals to be more efficient and to deal with problems of underutilization. This system has encouraged reductions in beds and service and in some cases facility consolidation.

The system also includes a series of disallowances for excess length of stay. Such a system, we believed, was quite important given the fact that our system pays on a per diem basis. So one of the ways to beat the system is just to add to length of stay and get paid more days. In essence, we have tried to solve that by setting length-of-stay standards for the system as a whole.

The final important part is a recently added aspect, and that relates to volume adjustments. Again, as an incentive to reduce utilization, the system recognizes the fixed costs of providing care if volume decreases. We pay for decreased volume at approximately 80 percent. But it recognizes only variable costs if volume increases beyond a certain level.

New York's original cost-containment program began in 1970, and while it covered Blue Cross and medicaid payments, approximately 40 percent of hospital revenues, these programs were only loosely linked.

From 1976 through the current period, statutory and regulatory changes have improved New York's cost-containment program and more closely linked medicaid and Blue Cross methodologies, and covered all other payers with the exception of medicare. So we now control about 60 to 65 percent of hospital revenues.

As our control of an increasingly large share of hospital revenues became more effective, we found that the ability of hospitals to shift costs from one payer to another was very much limited. One of the results of this has been that a number of hospitals in New York State have suffered operating losses. These losses have resulted primarily from three factors:

First, providing care to those who cannot pay—the bad debt and charity care, which is a problem, as noted earlier, that has been solved to a great degree in the Maryland system and perhaps in the New Jersey system.

Second, the difference in third-party reimbursement, especially the difference between the way in which medicare reimburses, compared to other payers.

Then, finally, from the inability of institutions to operate efficiently and to contain yearly increases within the rate of inflation.

As was noted, we are currently working to improve our cost containment program, focusing in on these problems by recognizing the cost of bad debt and charity care and by eliminating losses from the differences in third-party payer formulas, while at the same time increasing incentives for efficient operation.

To accomplish this, New York State has submitted a request to the Health Care Financing Administration requesting a medicare waiver, which would allow medicare to participate in New York State's reimbursement system.

The highlights of this proposal include: prospective cost-based rates which would be set for all major hospital payers, including medicare; a 3-year revenue cap trended forward for inflation—3 years to give the industry some predictability and stability; adjustments for changes in hospital volume, case mix, and service changes; regional funding to help offset the cost of bad debt and charity care; regional funding to aid financially distressed hospitals; discretionary fund allowances to provide additional working capital to hospitals; and a continuation of the peer group ceiling

and other performance standards that have been part of our system.

As was noted by one of the previous speakers, this proposal comes with a reasonable amount of consensus within New York State among the health leaderships within the assembly and the Senate, the Hospital Association of New York State, and the executive branch. And we are at a point where I believe we must make these changes, given the history of New York State's program and the problems that we have identified with it, if we are to continue to maintain a strong cost-containment program within the State.

Let me deal briefly with the other two legs of this stool I referred to.

In 1964, New York State established the first certificate-of-need program. Our health planning program has been effective and an effective complement to our overall cost-containment program. Since 1975, through reimbursement and planning, we have moderated capital expenditures and removed over 12,000 excess beds from our hospital system, increased the efficient use of our remaining beds, and encouraged the development of alernative modes of care.

However, we are now facing new problems which have the potential of restarting the cycle that we found ourselves with in 1975 when many of the reimbursement programs were put into place.

To give you a sense of that problem, let me quickly scope out the levels of approvals of capital expenditures in New York State over the past several years:

In 1979 the State approved $236 million worth of new projects.

Three hundred and sixty-nine million were sanctioned in 1980.

Last year, capital projects with initial cost estimates of $815 million were approved.

This year we are facing requests for capital expenditures of close to $3 billion.

Senator DURENBERGER. Is this all hospitals?

Mr. CRANE. It is not all hospitals. This would include hospitals, long-term care facilities, and ambulatory care facilities. The majority of it, however, is in the hospital sector.

This figure is well in excess of anything that we consider reasonable or acceptable in an era of limited and contracting resources. And, clearly, if that amount is approved, taking the capital costs, the related operating costs, and the costs of financing that capital in today's environment, we are looking at substantial increases to both third-party payers, private payers in New York State, and to the medicare and medicaid programs.

It may be not unreasonable to assume that the cost to medicare alone from that package of expenditures could reach $6 billion over a period of time.

We are working actively to deal with this issue. One of the issues we have been charged by Governor Carey to examine is the notion of developing a system which would, in our planning process, consider relative need as opposed to absolute need, trying to identify these projects which are most important with which to proceed. And we have a blue ribbon panel which is helping us think through that issue, hopefully developing a solution before the end of the year.

The final leg of the stool deals with utilization review, and the testimony goes through a litany of things which we have done to try to strengthen utilization control. I would only underscore the importance of that as a complementary piece.

Senator DURENBERGER. Excuse me. I think we had better leave it with that.

Mr. CRANE. All right.

[The prepared statement of Robert M. Crane and answers to questions from Senator Durenberger follow:]

Mr. Robert M. Crane
Director
Office of Health Systems Management

Before the Senate Finance Committee
Wednesday, June 23, 1982
Washington, D.C.

ON

Hospital Cost Containment in New York State

Mr. Chairman, members of the Senate Finance Committee, I am Robert M. Crane, Director of the New York State Office of Health Systems Management. I appreciate the opportunity to testify before you today because we in New York have faced the problem of containing rising health care costs.

In many ways, New York's seemingly large and complex hospital system is a microcosm of the nation's hospital system.

- New York's hospitals range in size from 20-bed community hospitals in isolated rural communities, to 1,000-bed big-city medical centers serving patients from all over the world, and with yearly budgets that exceed the Gross National Product of some nations.
- The cost of hospital care in New York is remarkably similar to nationwide hospital costs. In 1980, the average cost of a hospital day in New York was $255. Nationwide, the cost of a hospital day was $246. If we exclude the City of New York from our calculation, the average cost of hospital care in upstate New York was only $207 a day.
- In New York, voluntary hospitals account for 75 percent of total hospital beds, proprietary hospitals 8 percent, and public hospitals 17 percent. Nationally, voluntary hospitals account for 70 percent of all hospital beds, proprietary hospitals 8 percent, and public hospitals 22 percent.

- New York has 3.9 beds per 1,000 population, while nationally this figure is 4.5 beds per 1,000 population.

And by virtually any measure, New York's hospitals are a major part of the nation's hospital system.

- New York has 8 percent of the nation's hospital beds.
- New York's hospitals employ more than 10 percent of the nation's hospital workers.
- Hospital expenditures in New York account for 10 percent of the nation's hospital expenditures, and 10 percent of Medicare's expenditures for hospital care.
- New York has 15 percent of all teaching hospitals in the nation and trains more new doctors than any other state.

The problem New York has faced, and the problem now more clearly confronting the nation, is how to meet the demand for essential public services, such as health care, while confronting fiscal and economic realities. I cannot say that we have the perfect solution, nor can I say that our solution is problem free, but I can say that New York has been successful in containing health care costs.

Between 1975 and 1979, total hospital costs in this country increased by 64 1/2 percent, while New York's hospitals increased at less than half that rate, 31 percent. During the same period, national per capita hospital expenditures increased by 58 percent, while during that same period, per capita expenditures in New York increased by only 35 percent.

In 1980, New York's per diem hospital costs went up by 11 percent, while national hospital costs rose by 14 percent.

Our success has been based on three principles:

1. effective prospective rate setting;
2. effective health planning; and,
3. effective utilization control.

New York's Public Health Law provided the statutory framework for this strategy. Under this law, we were required to establish prospective rates of payment related to an efficient production of services. Because of the size and complexity of New York's health care system, we started with a formula-based methodology rather than a time-consuming budget review process.

We then adopted the principle that the best way to measure a hospital's efficiency is to compare it to its peers. We developed groups of similar hospitals using a variety of factors such as size, location, teaching versus non-teaching, average age of the hospital patients, case mix, and so on. We then set up reimbursement ceilings at slightly above the average routine and ancillary cost for each group. In effect, we made the average cost our basic standard of an efficient production of services. We then permitted any hospital with costs exceeding this standard to appeal based on a wide variety of factors.

We further refined this system by incorporating a system for disallowing the unnecessary cost of excessive patient lengths of stay. We felt that this was a particularly important measure because excessive and unnecessary patient stays are too often a common cause of escalating hospital costs. In addition, since the system pays on a per diem basis, we wanted to counteract any incentive to increase patient days thru longer hospital stays.

We also included in our rate methodology a system for disallowing the unnecessary costs incurred by hospitals with chronically low occupancy. Empty beds and expensive equipment lying unused for a large part of each day is another common cause of high unit costs...and without doubt, one of the least defensible. We developed a schedule of minimum utilization standards that took into account the type of service, e.g., medical/surgical, obstetric, open heart surgery...and the physical location of the hospital. We also provided for the special circumstances of isolated rural hospitals.

We then refused to reimburse hospitals for the extra per diem cost when occupancy fell below these standards. This provision was not only effective in reducing expenditures, but it provided an incentive for consolidations, mergers, and closures.

We then included a volume adjustment that rewarded hospitals for reducing patient hospital days. We reimbursed any hospital able to reduce patient days below a predetermined target approximately 80 percent of their per diem rate of payment for every day of care below the target that the hospital did not provide in order to cover fixed costs and encourage appropriate utilization. Conversely, we reimbursed any hospital unable to control patient days only 20 percent of their per diem rate of payment for every day of care they provided above this target in order to cover variable costs.

New York's original cost containment programs began in 1970, and while covering Blue Cross and Medicaid payments -- approximately 40 percent of hospital revenues -- to hospitals these programs were only loosely linked. From 1976 through the current period, statutory and regulatory changes improved the effectiveness of New York's cost containment programs, closely

linked Medicaid and Blue Cross reimbursement methodologies and covered all other payors except Medicare -- including hospital revenues from private paying patients. In total, our programs now cover approximately 60 to 65 percent of all hospital revenues.

However, as our control of most hospital revenues became more effective we eliminated the ability of a hospital to shift costs from one payor to another. The result has been that a number of hospitals in New York has suffered operating losses. They have resulted primarily from:

1. providing care to those who cannot pay (bad debt and charity care);
2. the differences in third-party reimbursement, especially the difference between Medicare and other payors; or,
3. from an inability to operate efficiently or to contain yearly cost increases to within the rate of inflation.

We are currently working to improve our cost containment program by recognizing the cost of bad debt and charity care, and by eliminating losses from the differences in third-party reimbursement formulas while at the same time, increasing incentives for more efficient operation.

Two months ago, New York State submitted a request to the federal Health Care Financing Administration entitled, "A Proposal for the Development of a Reimbursement Methodology for New York for the Eighties." The highlights of this proposal are:

1. prospective cost-based rates for all major hospital payors including Medicare;

2. a three-year revenue cap trended each year for inflation;
3. adjustments for changes in hospital volume, case mix, and services;
4. regional funding to help offset the cost of bad debt and charity care;
5. regional funding to aid financially distressed hospitals;
6. discretionary fund allowances to provide working capital to hospitals;
7. peer group cost ceilings and other performance standards; and,
8. more specific links to health planning and certificate of need.

We believe that this proposal is essential to the stability of New York's hospital industry, and to the continued success of New York's cost containment program.

We in New York have also learned the necessity and value of joining rate setting to strong health planning programs and to strong utilization review programs.

In 1964, New York began the nation's first certificate of need program. Our health planning program has become an effective complement to our cost containment programs. Since 1975 and through these programs, we have moderated capital expenditures and removed over 12,000 excess beds from our hospital system, increased the efficient use of our remaining beds, and encouraged the development of alternative modes of care. However, we are now facing a new problem, one which has the potential of restarting the cycle of escalating costs, forcing increased taxes, and jumps in employee health insurance costs.

The scope of the problem quickly becomes evident when we look at the statistics on the total dollar amounts of capital construction in health care approved by New York State over the last few years. In 1979, the State approved $236 million in new projects, and $369 million was sanctioned in 1980. Last year, capital projects with initial cost estimates of $815 million received State approval. This year, we are faced with projects totalling nearly $3 billion. This figure is well in excess of anything which we consider reasonable or acceptable in an era of limited and contracting resources.

By some estimates, the total capital costs including interest costs, could be $10 to $15 billion. The cost to the federal Medicare program alone could be $6 billion.

What is our response to this development? If there truly exists a demand for $3 billion worth of construction to keep our health care delivery system operating in an effective, efficient, and responsible manner, then there must be some way of determining which projects are absolutely necessary now, which are deferrable, and which can be reduced in size and scope in order to meet needs while reducing costs. If a lesser amount is required, we must be able to determine the bare minimum. In February of this year, in his Annual Health and Human Services Message, Governor Carey identified the Department of Health's obvious responsibility to develop, "a capital allocation process to consider the relative, rather than absolute, merits of any certificate of need application."

We have already begun to address this issue. A "blue ribbon panel" appointed by the Commissioner of Health is assisting us in this task. They will look at such issues as: the need for capital expenditures in the State, whether or not we should allow hospitals to make capital investments when interest rates are high, and how we can determine the relative need of the proposed capital investments that are before us.

New York State has also pursued a strong program for utilization review. Working with the Professional Standards Review Organizations (PSROs), we designed a utilization review program that:

1. targetted effective reviews;
2. prohibited weekend admissions except for emergencies;
3. provided incentives for preadmission testing;
4. required an independent second opinion for all overutilized and high risk procedures;
5. provided reimbursement penalties for unnecessary preoperative stays of more than one day; and,
6. provided reimbursement incentives for performing some surgical procedures on an outpatient basis.

Over the last several years, there has been a noticeable decline in the average number of days patients stay in New York hospitals.

In conclusion, I only add that New York has been successful in controlling costs. New York's cost containment program has provided medical facilities with the incentive for efficiency and the will to contain yearly cost increases. But, we are now working on a better system:

1. a system that allows all payors, including Medicare to use a prospective rate setting formula;
2. a system that covers several years and provides the hospital industry with stability;
3. a system that provides incencives for efficiency and economy;
4. a system that is used by all payors and eliminates the differences in third-party reimbursement programs;
5. a system that can be sensitive to individual hospitals and special community needs; and,
6. a system that is tied to effective health planning and utilization control.

I encourage this Committee to build upon the lessons that we in New York have learned. Perspective reimbursement for Medicare and Medicaid is a necessary but not a sufficient next step. It is not sufficient because it would still allow hospitals to continue to avoid hard management decisions by merely shifting costs to non-Medicare/Medicaid patients. States given the proper incentives and encouragement can solve this problem by further refining or creating programs that apply these principals to all third-party payors. Such programs can be designed to recognize unique hospital problems and can be closely tied in a synergistic manner to health planning, utilization review, and other State run programs.

We urge the Committee to move in this direction.

Thank you.

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STATE OF NEW YORK
DEPARTMENT OF HEALTH OFFICE OF HEALTH SYSTEMS MANAGEMENT
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DAVID AXELROD, M.D.
Commissioner

ROBERT M. CRANE
Director

September 22, 1982

Mr. Robert E. Lighthizer
Chief Counsel
Committee on Finance
Room 2227
Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Lighthizer:

Mr. David Durenberger has requested that I direct to you my responses to a series of four questions that he has posed concerning my testimony to the Senate on June 23, 1982 regarding state hospital payment systems. My responses, and several attachments, are enclosed. Please do not hesitate to contact me if you need any additional information.

Sincerely,

Robert M. Crane
Director
Office of Health Systems Management

kbk
Enclosure(s)

Question 1: Why do you believe a three year revenue cap, trended for inflation, is more desireable than establishing an annual figure?

Response: A three-year revenue cap provides hospitals with a predictable, stable revenue base. Predictability and a degree of stability in revenue flows are prerequisites of sound long term financial planning for both hospital administrators and third party payors. Additionally, incentives to control cost are strengthened as the base year will not change for the three year period. Establishing an annual figure, possibly based upon the introduction of new cost containment incentives each year, not only helps to generate an uncertian revenue environment (thus placing long-term resource allocations on rather tenuous ground), it also vitiates the good faith attempts of hospitals to respond to presumably reasonable cost controls one year because these cost controls may be substantially changed the following year. A three year methodology is a message to the hospital industry that third party payors have developed an empirically sound and equitable reimbursement methodology that they are willing to maintain for more than just a year. We are comfortable with this three year commitment and confident that it protects the interests of both the people of the State of New York and the hospitals upon which they rely. The support of the hospitals in New York State indicates that they share our confidence and are equally content with the long term commitment to the methodology we have jointly developed.

Question #2: Would you explain your procedures in determining unnecessary cost related to excessive patient lengths of stay and other unnecessary costs incurred by hospitals as indicated in your statement.

Response: Three standards have been developed to evaluate the cost performance of non-specialty hospitals. One standard, applied to the professional component costs (physicians, interns and residents, and supervising physicians), will hold these costs to a base-to-base (e.g., 1980 to 1981) limitation reflecting the physician's salary component of the New York State inflation factor.

A second standard is applied to ancillary costs measured on a per discharge basis.

Each hospital's ancillary costs are held to a case-mix-adjusted standard equal to 105% of its peer group's average ancillary cost, i.e., those ancillary costs in excess of 105% of the group average are disallowed. Because the ancillary cost standards depend on our peer grouping methodology as well as case-mix adjustment methodology, these are both described fully in Attachments A (Peer Grouping Methodology, B (Case-mix Index Calculation) and C (Examples of case-mix Adjustment to Peer Group Ceilings).

The third standard is applied to routine costs, and is most accurately described as a case-mix adjusted peer group average routine cost per expected day. In effect, our methodology adjusts each hospital's routine costs by case-mix as well as by expected length of stay (LOS), before these costs are compared to its peer group average routine cost. Again, we have placed a corridor on this group average, cost, recognizing cost differences between facility's control. In this case, the corridor is 7.5% above the group average, i.e., those routine costs in excess of 107.5% of the group average are disallowed. This routine cost standard is calculated on the basis of the same peer groups used for the ancillary cost standard calculations. The case-mix calculation, this time for LOS adjusted for case-mix, is described in Attachment D. The application of the facility's case-mix adjusted LOS to its routine costs, and the calculation of ceiling penalties, if any are described in Attachment E.

The three cost standards described above apply only to non-specialty hospitals. Specialty hospitals are "one of a kind" hospitals, whose case-mix and services are substantially different from regular acute hospitals. Such facilities include hospitals that admit only patients with certain diagnoses such as cancer and related diseases, or with diagnoses involving the eye and ear. Rehabilitation and psychiatric hospitals are also accorded specialty status. Attachment F fully describes the cost standards applied to specialty hospitals, but generally these hospitals are held to a base-to-base limitation based upon the allowable cost growth for non-specialty hospitals in the specialty hospital's Health Systems Agency (HSA) region.

Question #3: How were you able to eliminate the ability of hospitals to shift costs to patients not covered by your program?

Response: I believe that, in referring to our program, you are referring to the three major third party payors, Medicare, Medicaid and Blue Cross. We share your concern that, in our efforts to control the costs of Medicare, Medicaid and Blue Cross, we do not allow costs to be shifted to commercial insurers and private pay patients. We have addressed this problem by passing legislation to limit annual increases in hospital charges to the hospital price index which is adjusted for the ratio of current charges to costs in the facility. This legislation has the effect of gradually lowering the charge level. Beginning in 1984 a further change will be made by having Workers' Compensation and No Fault pay charges instead of per diem rates calculated from the Medicaid rates.

For 1984 and 1985, hospitals must set their charges such that the hospital's Blue Cross rate, adjusted for uncovered services, is at no more than a specified discount from the charge rate. For 1984 and 1985, this discount will not exceed twelve percent for those hospitals which had a discount of less than twelve percent during the previous year, will be no greater than the discount in effect during the previous year for those hospitals whose previous year's discount was between twelve and fifteen percent, and will not exceed fifteen percent for all others. For 1986 this discount will not exceed twelve percent.

Question #4: Does your program take into account cost differences between teaching/non-teaching, large/small and urban/rural hospitals?

Response: We do indeed recognize these cost differences through both our grouping methodology and adjustments to specific hospital costs such as wages and energy. Attachment G describes the wage equalization factor. Attachment H describes the power equalization factor.

The grouping methodology described in Attachment A, explicitly recognizes differences in teaching/non-teaching and urban/rural hospitals by partitioning all New York hospitals into four groups before any seed clusters, or peer groups, are developed. The four sets of hospitals created by the partitioning are upstate teaching, downstate teaching, upstate non-teaching and downstate non-teaching.

A separate set of grouping variables is developed for teaching hospitals and for non-teaching hospitals. Within each set of grouping variables is a variable which constitutes a measure of size, i.e., total number of certified inpatient beds. The grouping variables, however, acknowledge a far wider set of cost-influencing variables than a hospital's location, teaching status and size. The grouping variables also account for cost differences explained by such factors as patient age, payor mix, services provided, case-mix and occupancy. As shown in Attachment A, in 1982 there were nine grouping variables for teaching hospitals and 11 for non-teaching hospitals.

Attachment A

1982 GROUPING METHODOLOGY (to be used in 1983 as well) & 1982 GROUPING VARIABLES

Methodology

New York State uses a grouping methodology called seed clustering.

What is seed clustering? Seed clustering is a process or algorithm which identifies for each groupable hospital (called the "seed" hospital) at least four but no more than 14 other hospitals most similar in terms of the values of the "grouping" variables (Note: group size then can vary from five to 15).

How are variables selected? Regression analysis; t-statistics and r-squared are used to judge quality of the variables.

Once variables are selected, then what? Ultimately, we would like to compare each of the seed hospital's grouping variables to the corresponding grouping variable of every other hospital in the universe and compute a difference and then somehow summarize these differences across all variables for all hospital pairs. Therefore, if there are (say) 16 grouping variables and (say) 60 hospitals, then 59 sets of 16 grouping variable differences must be calculated for each seed hospital and somehow the 16 differences must be summarized for 59 pairs. But the 16 grouping variables are all in different dimensions (e.g., number of certified beds, number of extracorporeal procedures), how can the differences be summarized? The grouping variables are just Z-scored for every hospital so they are all measured in the same dimension (i.e., standard deviations from the population mean).

Are all variables weighted equally? No, the variables are weighted by the beta weights (i.e., standardized regression coefficients) from the regression equation.

How are the 16 grouping variable differences between the seed hospital and each of the other hospitals with which it can be grouped summarized? A summary measure, called the seed distance, is computed. The seed distance, also called euclidean distance, is the square root of the sum of the squared differences.

What happens after the seed distances between the seed hospital and every other hospital with which it can be grouped are computed?

a. Ranking: The hospitals are rank ordered (from the closest to the farthest seed distance) from the seed hospital.

b. The "Natural Break" is then computed at largest pairwise difference in seed distances.

c. Second cut point computed as 1.4 times the average seed distance of the first five hospitals.

d. The smaller group size (but at least five) is determined from b and c above.

Example 1: Find a group for the first of ten men based upon weight.

Man	Weight	Z-Score	Seed Distance from Man #1
1	160	$\frac{160-187.5}{22.6} = -1.22$	---
2	180	-.33	$0.89 = 1 * (-1.22-(-.33))^2$
3	175	-.55	0.67
4	190	.11	1.33
5	205	.77	1.99
6	150	-1.66	.44
7	210	.96	2.18
8	230	1.88	3.10
9	195	.33	1.55
10	180	-.33	.89

$\bar{X} = 187.5$ $\sigma = 22.6$

Rank Order from Man #1:	Man	6	3	2	10	4	9	5	7	8
	Seed Distance	.44	.67	.89	.89	1.33	1.55	1.99	2.18	3.10
	Weight	150	175	180	180	190	195	205	210	230
Group Cut after Man #7:	Pairwise Differences	---	---	---	---	.44	.22	.44	.19	.92*
Group Cut after Man #10:	Second Cut Point	$= ((.44 + .67 + .89 + .89)/5) * 1.4 = .81$								

Group for Man #1 = 6, 3, 2, 10

Example 2: Find a group for the first of ten men based upon height and weight (the similarity or weight is more important than height, so weight, weight and height, .75 and .25, respectively).

Man	Weight	Weight Z-Score	Height	Height Z-Score	Seed Distance from Man #1
1	160 lbs.	-1.22	5.8 ft.	0	---
2	180	-.33	6.0	0.8	$.89 = .75(-1.22+.33)^2+.25(0-.8)^2$
3	175	-.55	5.6	-0.8	.70
4	190	.11	6.0	0.8	1.22
5	205	.77	6.1	0.8	1.77
6	150	-1.66	5.5	1.2	.71
7	210	.96	5.7	-0.4	1.90

Man	Weight	Weight Z-Score	Height	Height Z-Score	Seed Distance from Man #1
8	230	1.88	6.2	1.6	2.80
9	195	.33	6.0	0.8	1.40
10	180	-.33	5.8	0	.77
		$\bar{X}$ = 187.5		$\bar{X}$ = 5.8	
		σ = 22.6		σ = .25	

Rank Order from Man #1 :	Man	3	6	10	2	4	9	5	7	8
	Seed Distance	.70	.71	.77	.89	1.22	1.40	1.77	1.90	2.80
	Weight	175	150	180	180	190	195	205	210	230
	Height	5.6	5.5	5.8	6.0	6.0	6.0	6.1	5.7	6.2
Group Cut after Man #7 :	Pairwise Differences	---	---	---	---	.33	.18	.37	.13	.90*
Group Cut after Man #2 :	Second Cut Point	= ((.70 + .71 + .77 + .89)/5) * 1.4 = .86								

Group for Man #1 = 3, 6, 10, 2

Grouping Variables Used

Upstate Teaching Hospitals

1. Average patient age
2. Percentage of Medicaid days x percentage of Blue Cross days
3. Blue Cross service index
4. Total number of certified inpatient beds
5. Occupancy Percentage
6. Total number of residents and fellows per bed
7. Percentage of Medicaid days
8. Total Number of extracorporeal procedures
9. Case Mix factors

Downstate Teaching Hospitals

(Same grouping variables as upstate teaching hospitals)

Upstate Non-Teaching Hospitals

1. Percentage of Medicaid days x percentage of Blue Cross days
2. Percentage of new cancer registry cases per discharge
3. Blue Cross service index
4. Total number of certified inpatient beds
5. Occupancy Percentage
6. Total number of residents and fellows per bed
7. Percentage of surgical days
8. Ratio of ancillary costs to routine costs (less professional components)
9. Percent of Medicaid days
10. Average patient age
11. Case Mix factors (which measure variation in proportion of cases in major diagnostic categories - autogroup patient classification scheme and diagnostic related groups)

Downstate Non-teaching Hospitals

(Same variables as upstate non-teaching hospitals)

Attachment B

CASE MIX INDEX CALCULATIONS

A. Introduction

The 1983-1985 hospital reimbursement methodology contains an automatic case mix adjustment to the cost ceilings applicable to a facility's rate. This adjustment recognizes differences in case mix between the facility and the group that it is compared to for ceiling purposes. Changes in the facility's case mix from the base year used in the rate calculation to the rate year will continue to be adjusted upon appeal. This chapter provides a background of the State's approach to recognizing case mix differences and the effect of these differences on costs. It also provides the methodology to implement the case mix adjustments.

B. Background

Case mix has been a major focus of attention in the hospital industry during recent years. Research studies have demonstrated that the complexity of case mix can account for a significant amount of the cost differences found among hospitals. This information has motivated the OHSM to institute methods which would appropriately take into account differences among hospitals' case mix. Case mix reimbursement methods have been implemented in Maryland, New Jersey and Georgia, and are being considered for national application by the Medicare program.

New York State began to develop its expertise in case mix in 1978 with funding by the Federal Health Care Financing Administration of the New York State Case Mix Study (CMS). The Case Mix Study is conducted under the auspices of OHSM and with the assistance of the Hospital Association of New York State (HANYS). Participants were recruited by CMS and HANYS to obtain a stratified 10% sample of acute care institutions located in areas throughout the State. Each participant supplied the Study with the following basic data: (a) an itemized patient bill and medical record abstract for each 1978 discharge; (b) a copy of the Uniform Financial Report (UFR) submitted annually to third party payors for reimbursement rate computations; and (c) a Financial Questionnaire designed by CMS to identify in detail the cost of each hospital department reported on the UFR. Participating hospitals receive management reports relating to case mix data including hospital costs organized by Diagnosis Related Groups (DRG), a patient classification system developed at Yale University.

Several patient classification systems can be used to determine the mix of cases treated in a hospital including: (a) Diagnosis Related Groups (DRGs); (b) isocost groups (John Hopkins University); (c) patient management algorithms (Blue Cross of Western Pennsylvania); (d) Disease Staging technique (Systemetrics); and (e) information theory (Maryland Health Services Cost Review Commission/John Hopkins University). With the exception of DRGs, these schemes are still largely in development stages. Currently, OHSM believes that DRGs are the most viable classification system available for the purpose of identifying overall resource consumption.

Patients are assigned to one of 383 DRGs on the basis of primary and secondary diagnoses, operative procedures, and age, all of which are reported on the medical record abstract. Each DRG represents an aggregation of similar diagnoses that are consistent in terms of their anatomical and/or physiopathological characteristics. In addition, the classification method is sensitive to secondary complications, operative procedures performed for the patients, and, to a moderate degree, patient age. Since 383 mutually exclusive DRGs are used, analysis of case mix is available in terms of manageable number of groups, most of which possess a substantial number of cases.

Matched hospital discharge data and bills are costed into DRGs through a cost finding process. Tables 1 and 2, attached, illustrate the summary reports that can be generated. Table 1 provides the average cost per case for each of five (5) hospitals for six DRGs. Table 2 provides detailed cost information for five (5) hospitals for a particular DRG.

Average cost per case or day is used to establish a relative value for case complexity in each of the 383 DRGs.

From the data in Table 2 (collected and processed for 31 New York State hospitals for the 1978 base year), four major indices can be computed for each DRG: ancillary cost per case, routine cost per day, total cost per case and total cost per day. The computational approach used is the same for all four indices. The steps necessary to determine the routine cost per day index is as follows:

Step 1. For all the hospitals in the study determine the total routine costs applicable to each DRG and also the total days applicable to each DRG.

Step 2. Determine the average cost for each DRG by dividing total costs by the total days for each DRG.

Step 3. Determine average cost per day for all patients by dividing total costs by total days.

Step 4. The relationship of each DRG's average cost per day to average cost per day of all patients forms the index for that particular DRG. For example, if the average cost per day for the DRG is $300 and the average for all patients is $250, the index for the DRG is 1.2.

Since the average for all patients is "1", indices greater than 1 indicate cases more expensive than the average and those less than 1 indicate cases less expensive than the average. Table 3 is a sample of some of the weights which were calculated for each DRG based on an operational cost per day. The weights show that DRG #1 (Diarrheal enteritis under age 16, wgt. .665) costs less per day to treat than DRG #127 (Ischemic heart disease except AMI with shunt oper, other major operations, wgt. 2.099).

The case mix index for a hospital is developed by taking the hospital's discharges or days for each DRG and calculating a weighted average across all DRGs for the hospital (an example calculation is shown in Table 4). The group average is calculated the same way but using the entire group's data. Hospital specific and group average case mix index numbers are shown in Table 5.

TABLE 1

RANK ORDER AVERAGE COST PER CASE IN SIX DRGs

TEACHING HOSPITALS A,B,C,D, & E

DRG	Description	Rank	Average Cost Per Case.				
			A	B	C	D	E
127	Ischemic Heart Disease Except AMI with Shunt or Other Major Operation	1	11689	7317	6547	8739	12930
121	Acute Myocardial Infarction	2	5018	3463	6087	5250	6238
23	CA of Breast with Operation without Secondary Diagnosis	3	2470	2202	3697	2581	2461
204	Abdominal Hernia of Age Over 64 with Minor Repair Operation	4	1530	1834	2906	1851	1759
158	Hemorrhoids	5	1304	1519	1678	1304	1324
159	Acute URI or Influenza of Age Under 45	6	566	776	836	661	736

Source: 1977, New York State Case Mix Study, Phase I. Case Mix Profile Analysis.

TABLE 2

PROGRAM-ID CMS80 — CASE MIX COMPARATIVE ANALYSIS — RUN DATE 04/26/80

PERIOD 1978 — COMPARISON OF HOSPITALS IN GROUP — REPORT 4162 PAGE 19

VERSION FULL COST (UNLEVELLED) — COMPOSITION OF TOTAL AVERAGE COSTS/CASE — GROUP ... HOSPITALS

DRG-075 DESCRIPTION-DIABETES NO OPER W MAJOR DX

HOSPITAL	TOTAL	0001	0002	0003	0004	0005				
COST $$d (K 1000)	3:34	3:31	3:19	3:11	4:20	3:27				
COST $$d (LO 0001)	10:0	9:4	10:1	8:2	10:9	10:4				
AVERAGE LOS	10.4	7.2	13.5	5.6	6.5	9.5				
NUMBER OF CASES	441	72	133	56	65	45				
ANCILLARY SERVICE - COST CENTERS	COST	COST	COST	COST	COST	COST	COST		COST	
OPERATING/REC RMS	6	1	3	1	1	9				
DELIVERY RMS										
X-RAY DX	170	139	237	146	59	214				
X-RAY TX										
LAB	336	420	364	184	177	420				
E.K.G.	4	4	4	3	3	4				
PHYSICAL TX	10	1	20	4	1	3				
INHALATH TX	1	1	1	1		1				
BLOOD	2		2	2		2				
PHARMACY SOLD	24	104	8	13	13	14				
MEDICAL SUPPLIES SOLD	10		7	10	11	7				
DIALYSIS										
CARDIAC SERVICES	10	29	13	16	15	24				
KIDNEY ACQ										
SKIN	1			8						
GASTRO										
FRACTURE ROOM										
HEARING/SPEECH										
ANCILLARY-OTHER		3								
SUB-TOTAL ANCILLARY SERVICES	626	732	680	432	328	746				
ROUTINE SERVICE - COST CENTERS	COST	DAYS	COST	DAYS	COST	DAYS	COST	DAYS	COST	DAYS	COST	DAYS	COST	DAYS	COST	DAYS
INPATIENT ACUTE	1,754	10.1	1,390	9.8	2,044	11.1	1,178	8.3	1,731	10.2	1,822	10.3				
I.C.U.	61	.1	32	.1	172	.3	23		38							
C.C.U.			11													
KIDNEY DISEASE	14		84	.3												
NEONATAL ICU																
MATERNITY	1				13	.1										
NURSERY ROUTINE																
NURSERY PREMAT																
BURN CENTER																
DETOX																
AMB SURG																
OTHER ROUTINE																
SUB-TOTAL ROUTINE SERVICES	1,835		1,518		2,819		1,483		1,816		1,843					
** TOTAL AVERAGE COSTS	2,462		2,243		3,000		1,936		2,144		2,468					

Table 3

Examples of Service Intensity Weights for Selected Diagnositc Related Groups

DRG #	Description	Routine/Day SIW	Ancillary/Cost SIW	Cost/Day SIW
1	Enteritis Diarrheal Dis of Age Under 16	.851	.205	.665
12	Ca of Resp Syst WO Oper WO DX2	.926	.641	.830
15	Ca of Resp Syst W Bipsy, Endoscpy, Oth Minor Oper W DX2	.991	1.884	.950
73	Diabetes of Age Under 36 WO Oper WO DX2 or W Minor DX2	.826	.384	.672
97	Epilepsy, Migraine, Brain Dis (Unspec) WO Oper WO DX2	.877	.408	.747
120	Hypertensive Heart Dis W Oper	1.159	1.492	1.112
127	Ischemic Heart Dis Except AMI W Shunt Oper, Oth Major Oper	1.564	5.837	2.099
145	Pneumonia of Age Under 31	.837	.356	.693
223	Liver Cirrhosis WO DX2 or W Minor DX2	.904	.735	.848
230	Dis of Pancreas WO Oper	.898	.848	.848
288	Delivery With C-Section	1.046	1.308	1.113
314	Cong Anom of Ht (Valve,Unspec) W Oper on Ht (Valve,Septum)	1.525	4.950	2.039
318	Normal Mature Born	.722	.048	.463
336	Fx (Skull,Face,Forearm,Tibia, Fibula,Foot,Hand) WO Op, Age Lt 30	.988	.252	.800
368	Burn of 2nd Degr Compl, 3rd Degr, More Than 20% of Body	2.050	4.062	1.889

TABLE 4

CALCULATION OF CASE MIX COMPLEXITY INDEX AT THREE HOSPITALS

DRG	Ancillary SIW	Hospital A		Hospital B		Hospital C	
		Cases	Cases X SIW	Cases	Cases X SIW	Cases	Cases X SIW
1	.99	13	12.87	29	28.71	12	11.88
2	1.70	31	52.70	31	52.70	16	27.20
3	1.17	100	117.00	148	173.16	184	215.28
4	1.91	168	320.88	243	464.13	162	309.42
5	2.65	78	206.70	98	259.70	31	82.15
6	5.74	72	413.28	50	287.00	80	459.20
7	2.51	21	52.71	118	296.18	8	20.08
Total		483	1117.14	717	1561.58	493	1125.21
CMI			2.44		2.18		2.28

TABLE 5

Hospital and Group Case Mix Index Numbers (Ancillary)

Group Case Mix Index

DRG	Group Cases	SIW	Cases x SIW
1	54	.99	53.46
2	78	1.70	132.60
3	432	1.17	505.44
4	573	1.91	1094.43
5	207	2.65	548.55
6	202	5.74	1159.48
7	147	2.51	368.97
Total	1,693		3862.93

Case Mix Index = 2.28

	Cases	Case Mix Index
Hospital A	483	2.44
Hospital B	717	2.18
Hospital C	493	2.28
Group	1,693	2.28

Attachment C

EXAMPLES OF CASE MIX ADJUSTMENT TO PEER GROUP CEILINGS

(i) Facility Which is More Complex Than its Peers

Before Case Mix Adjustment:

Facility's routine cost per day	$230
Group average with 5% corridor	210
Routine disallowance	$ 20

Case Mix Adjustment

Facility's routine case mix index	1.10
Group average index	1.00
Difference	.10
% facility's case mix more difficult than group average	10%
Group average routine cost per day (without corridor)	$200
% facility's case mix more difficult	10%
Adjusted group average	$220

Since this adjusted group average (without a corridor) exceeds the previous ceilings, the facility's new routine cost ceiling will be $220, which results in an adjusted routine disallowance of $10 a day. If the adjusted group average did not exceed the ceiling, the ceiling will have remained as before.

(ii) Facility Which is Less Complex Than its Peers

If a facility's case mix index is less than that of the group, there will be an adjustment only if the facility's index is more than 5% below the average. The group average cost would be decreased by that portion of the percentage that exceeds 5% and the original 5% corridor then added to this adjusted group average.

Case Mix Adjustment

	A	B
Facility's routine case mix index	.97	.90
Group average index	1.00	1.00
Difference	-.03	-.10
% facility's case mix less difficult than group average	3.0%	10.0%
Group average routine cost per day (without corridor)	$200	$200
%facility's case mix less difficult	3.0%	0%
		Adjust by 5%
Adjusted group average	No adjustment	$190
Add original 5% corridor	less than 5%	10
Adjusted routine cost ceiling	$210 (same as original)	$200

Attachment D

CASE MIX ADJUSTED 1982 LOS STANDARDS (Methodology to be used in 1983-1985 as well)

Statewide hospital case mix data were clinically and statistically analyzed to determine the major age/diagnostic cells (MADC's) suitable for the purpose of setting the 1982 LOS standards. Five hundred forty-two (542)MADC's were identified as being significant, resulting from collapsing 4,316 original cells (83 major diagnostic categories, 13 age categories, the presence or absence of surgery, and the presence or absence of secondary diagnosis).

Table 1 shows, for illustrative purposes, the results of collapsing the 52 original cells (13 age categories, the presence or absence of surgery and the presence or absence of secondary diagnosis) for the major diagnostic categoy, Infectious Diseases. The analysis indicated that the significant age categories for Infectious Diseases are: less than or equal to 30, greater than or equal to 31 but less than or equal to 80, and greater than 80. The presence or absence of surgery and the presence or absence of secondary diagnosis were both determined to be significant; therefore, as the table illustrates, 4 cell divisions are retained for each new age category defined above. Since the original 13 age categories are collapsed into 3, only 12 (3 x 2 x 2) of the original 52 cells remain; these are indexed MADC's 1 through 12.

Certain of the original 4,316 were not collapsed because their small case frequently makes it difficult to derive meaningful statistical comparisons. For this same reason, these same cells were deemed non-comparable and so were excluded from the LOS standard computation.

DRG [illegible] TOTAL THORACIC
MAJOR DIAGNOSTIC CATEGORY 11 INFECTIOUS DISEASES

MADC INDEX	OLD DRG INDEX	AGE GROUP	PRESENCE OF SURGERY	PRESENCE OF SECONDARY DIAG.	TOTAL CASES	TOTAL LOS	MEAN LOS
1.	57.	UNDER 1	NO	NO	1,867	7,005	3.883
1.	61.	1-5	NO	NO	2,563	11,882	4.542
1.	65.	6-8	NO	NO	1,814	7,810	4.195
1.	69.	9-15	NO	NO	1,129	7,512	3.520
1.	73.	16-24	NO	NO	1,562	6,323	4.046
1.	77.	25-29	NO	NO	1,150	4,886	4.249
1.	81.	30-35	NO	NO	886	4,243	4.622
NEW MADC GROUP		*******	***	***	11,572	48,996	4.234
2.	59.	UNDER 1	NO	YES	1,492	8,181	5.481
2.	63.	1-5	NO	YES	2,867	15,254	5.243
2.	67.	6-8	NO	YES	1,598	7,892	4.535
2.	71.	9-15	NO	YES	1,277	5,756	4.507
2.	75.	16-24	NO	YES	837	4,592	4.866
2.	79.	25-29	NO	YES	625	4,686	5.053
2.	83.	30-35	NO	YES	730	4,847	6.695
NEW MADC GROUP		*******	***	***	9,646	49,962	5.148
3.	58.	UNDER 1	YES	NO	242	1,851	6.564
3.	62.	1-5	YES	NO	375	2,194	5.851
3.	66.	6-8	YES	NO	309	1,544	5.133
3.	70.	9-15	YES	NO	344	2,295	5.810
3.	74.	16-24	YES	NO	447	2,628	5.559
3.	78.	25-29	YES	NO	727	3,654	5.026
3.	82.	30-35	YES	NO	546	3,353	5.924
NEW MADC GROUP		*******	***	***	3,249	17,669	5.377
4.	60.	UNDER 1	YES	YES	253	2,575	10.178
4.	64.	1-5	YES	YES	369	3,121	8.455
4.	68.	6-8	YES	YES	238	2,000	8.739
4.	72.	9-15	YES	YES	256	2,650	8.008
4.	76.	16-24	YES	YES	320	2,582	8.069
4.	80.	25-29	YES	YES	448	3,780	8.473
4.	84.	30-35	YES	YES	463	5,216	12.903
NEW MADC GROUP		*******	***	***	2,256	21,870	9.348
5.	85.	31-39	NO	NO	1,848	8,442	6.877
5.	89.	40-49	NO	NO	859	6,991	7.437
5.	93.	50-64	NO	NO	767	5,671	8.437
5.	97.	65-89	NO	NO	344	4,125	7.316
NEW MADC GROUP		*******	***	***	3,819	21,016	7.948
6.	86.	31-39	NO	YES	1,869	9,138	6.779
6.	90.	40-49	NO	YES	1,037	10,473	9.714
6.	94.	50-64	NO	YES	1,084	20,483	18.314
6.	98.	65-89	NO	YES	2,531	28,126	11.142
NEW MADC GROUP		*******	***	***	6,591	67,166	10.196
7.	87.	31-39	YES	NO	448	4,287	9.616
7.	91.	40-59	YES	NO	367	3,602	9.863
7.	95.	51-64	YES	NO	376	3,869	10.290
7.	99.	65-89	YES	NO	219	3,259	14.881
NEW MADC GROUP		*******	***	***	1,409	14,721	9.537
8.	88.	31-39	YES	YES	486	9,269	18.190
8.	92.	40-59	YES	YES	549	10,595	17.956
8.	96.	51-64	YES	YES	1,036	20,737	20.133
8.	100.	65-89	YES	YES	1,319	29,454	21.942
NEW MADC GROUP		*******	***	***	3,436	69,678	19.966
9.	101.	OVER 89	NO	NO	165	1,330	8.115
NEW MADC GROUP		*******	***	***	165	1,190	7.236
10.	102.	OVER 89	NO	YES	1,247	18,716	14.669
NEW MADC GROUP		*******	***	***	1,250	16,666	13.368
11.	103.	OVER 89	YES	NO	39	877	18.795
NEW MADC GROUP		*******	***	***	39	432	11.368
12.	104.	OVER 89	YES	YES	488	11,944	24.719
NEW MADC GROUP		*******	***	***	483	11,716	24.257

TABLE 1

One hundred forty-seven thousand cases (6.0 percent of total cases) representing 6.7 percent of total days were excluded from groups suitable for standards.

Use of selected diagnoses for standard development involves two specific changes from prior year applications:

(1) Previously, a hospital's individual case mix-adjusted expected LOS was compared with its actual LOS derived from the annual financial report. Using selected diagnoses, however, requires comparing the hospital's expected LOS with discharge data submitted by the facility.

(2) To construct complete diagnostic case mix profiles for each facility, 1980 data were used.

Four unique sets of LOS standards were developed for the MADC's — one each for upstate teaching, upstate non-teaching, downstate teaching, and downstate non-teaching hospitals — to recognize the significant variations in lengths of stay among regions and by teaching status.

Attachment E

1983 COMBINED ROUTINE/LOS CEILING CALCULATION

The new combined routine/length of stay ceiling would use expected days rather than actual days in the computation of routine costs per day. The expected days would be calculated by multiplying the facility's expected length of stay standard (adjusted for all cases) times its actual discharges. A facility's expected length of stay standard would be calculated as it currently is in the determination of the length of stay disallowance. (See Chapter II - C)

(1) Hospital	(2) Routine Costs	(3) Actual Days	(4) Actual Discharges	(5) Adjusted Standard LOS*
A (Seed Hosp.)	$ 8,470	77	11	7
B	18,000	180	20	10.8
C	4,500	50	10	6
	$30,970	307	41	8.61

Hospital	(6)=(4)x(5) Expected Days	(7)=(2)-(6) Routine Cost Per Expected Day	
A	77	$110.00	$87.73 would be case mix adjusted. For illustration assume no adjustment necessary.
B	216	83.33	
C	60	75.00	$87.73 with a 7-1/2% corridor = $87.73 x 1.075 = $94.31 ceiling.
	353	$ 87.73	

For seed hospital A, routine cost per expected day less the Ceiling = $110.00 - $94.31 = $15.69
$15.69 x expected days = $15.69 x 77 = $1,208 disallowance.

* The present standard LOS is derived from a sample of cases. The actual hospital LOS of all cases can be either higher or lower than the actual LOS of these cases included in the sample. Therefore, the standard LOS should be adjusted to equal the ratio of actual LOS of all cases for that hospital to actual LOS of the sample for that hospital multiplied by the present standard LOS.

Attachment F

LIMITS ON ALLOWABLE COSTS FOR SPECIALTY HOSPITALS

Facilities Affected

Because of a substantially different case mix and substantial differences in the services provided compared to regular acute hospitals, there are several hospitals which historically have not had all their costs subjected to normal peer group standards. For 1980, these facilities were held to no routine or ancillary ceilings.

Specialty facilities include one of a kind hospitals, rehabilitation facilities and psychiatric hospitals. A list of these facilities in attached.

Proposed Cost Limits for Specialty Hospitals

Failure to consider any standard of efficiency for specialty facilities provides no incentive for these facilities to control costs. To provide a reasonable standard, therefore, a regulation was previously adopted which limits a specialty hospital's increase in operating cost per day for 1982 rates to the weighted average operating cost per day increase from 1979 to 1980 for non-specialty hospitals located in the specialty hospital's region--a base-to-base limitation. These limited costs would thereafter be increased by the trend factor similar to non-specialty facilities. Costs not included in the calculation of routine and ancillary ceilings would be excluded from this limitation. The regions used would be the Health System's Agencies (HSA's).

It is anticipated that specialty hospitals could appeal this limitation if the facility added significant approved new services in 1979, thereby causing excessive cost growth.

Examples of Calculation

a) Specialty Hospital A

1979 operating costs per day	$202.90
1980 operating costs per day	221.60
percent change	9.2%
average cost growth for region	8.5%

allowable 1980 base year operating costs = $202.90 x 1.085 = $220.15

b) Specialty Hospital B

1979 operating costs per day	$178.90
1980 operating costs per day	188.50
percent change	5.4%
average cost growth for region	8.8%

allowable base year operating costs = $188.50

RCC Adjustment

The RCC adjustment methodology, as described in a previous chapter of this text, will be applied subsequent to the cost limitation described above.

Facilities Subject to Limits on Allowable Costs for Specialty Hospitals

Unique Hospitals

Bellevue Maternity
St. Barnabas
Children's Hospital - Buffalo
Calvary
Roswell Park
Manhattan Eye and Ear
Memorial Hospital for Cancer
Hospital for Special Surgery
St. Francis - Roslyn
New York Eye and Ear
Kingsbrook Jewish
Detox Unit - Roosevelt - St. Luke's
Mental Retardation Institute

Rehabilitation Hospitals

B. S. Coler
Blythedale Children's
Brunswick - Rehab. Unit
Burke Rehabilitation
Children's Hospital - Utica
Goldwater
Helen Hayes
Institute of Rehab. Medicine
Monroe Community
Summit Park - Rehab. Unit
Sunnyview

Psychiatrics

Benjamin Rush*
Brunswick Hospital - Psych. building*
Falkirk*
Four Winds*
Freeport*
Gracie Square*
High Point*
Linwood Bryant*
Rye*
South Oaks*
N.Y. Hospital - Westchester division
Summit Park - Psych. Unit
St. Vincent's - Westchester division

* Article 31 facilities, no longer certified by the OHSM.

Attachment G

Wage Equalization Factor (WEF)

Purpose

The State has historically grouped hospitals without regard to location. This necessitated the development of a mechanism that would equalize each hospital's salary and salary-related costs, i.e. fringe benefits, to reflect differences in the price of labor. The wage equalization factor is designed to accomplish that goal.

Source Data

The WEF attempts to measure differences in salary prices, not differences in salary costs. Consequently, the data source must allow calculation of average salaries holding occupational mix constant.

Based on the recommendation by an ad hoc advisory group consisting of representatives of OHSM, the Hospital Association of New York State, and hospitals, OHSM developed a survey to measure average hourly rates by functional titles. These titles are as follows:

1) Nursing aides and orderlies
2) Licensed practical nurse (regardless of whether or not they are licensed to administer medication)
3) Registered nurse, nonsupervisory, including head nurse
4) Patient food service worker
5) X-ray technician (licensed or registered)
6) Laboratory technologist/technician
7) Housekeeping aides and attendants

WEF Methodology

The current methodology is the same as that used for 1981. The major advantage of the WEF methodology is that it allows facilities to be compared against statistics which are tailored to its employee mix. It does so by applying a standardized salary level to each hospital's own occupational mix. This has the effect of neutralizing the difference in wages and fringe benefits between facilities across the State.

Another advantage of the WEF is that it is hospital specific, that is, every hospital will receive its own unique WEF based upon its own data.

WEF is calculated as follows:

1. Calculate statewide weighted average salary for each occupation.
2. Calculate actual weighted average salary for each facility (weighted by actual hours paid exclusive of on-call and overtime hours).
3. Calculate weighted average salary for each facility using facility's occupation mix and statewide weighted average salary for each occupation.

Attachment H

Power Equalization Factor (PEF)

Introduction

Similar to the wage equalization factor, the power equalization factor is intended to adjust electric power costs so that differences in electric rate levels between hospitals are neutralized prior to peer group comparison. Use of a power equalization factor in the reimbursement system recognizes that the price paid by a facility for electricity varies from place to place and is not generally at the discretion of the facility.

The data base for calculating the PEF consists of:

1. Rate information for each of the seven utility companies in New York State. This information reflects rates per KWH across various consumption levels, demand changes, fuel adjustment changes, and seasonal rate differentials for each of the seven companies.

2. Average utilization levels for hospitals within each of the utility company's service areas based on a limited survey conducted by HANYS in 1974. These same utilization levels are currently used to compute electricity price movements as part of the trend factor computations.

Methodology

The methodology standardizes utilization to that of the "seed" hospital or the facility for which the ceiling is to be calculated and inflates or deflates the electricity cost of the other facilities in the seed hospital's group to adjust for differences in utility rate levels and rate structure.

$$\text{Differential} = \frac{\text{Cost per KWH of Seed Hospital at Seed Hospital Usage}}{\text{Cost per KWH of Grouped Element at Seed Hospital Usage}}$$

The following matrix represents costs per KWH based on three average utilization levels, and three different rate levels and structures.

Utilization	Rate Structure		
	CE	NIMO	LIL
Con Ed (Facility A)	$7.63	$3.38	$5.34
NIMO (Facility B)	7.64	3.38	5.60
Long Island Light (Facility C)	8.36	4.14	5.29

If Facility B's peer group ceiling were under consideration and Facility A and Facility C were in its group, the adjustments to electricity cost would be as follows:

Facility B	1.00	(3.38/3.38)
Facility A	.44	(3.38/7.64)
Facility C	.60	(3.38/5.60)

Senator DURENBERGER. I am going to have to take 5 minutes to go over and vote. And, Mr. Schramm, you have been sitting there for some period of time.

By way of suggestion, when I get back, one of the first issues I would like to deal with is the whole issue of capital, which is where Bob Derzon started.

That can be viewed several ways. One is the school closure example, which you used and was reacted to in Rochester. Another, from the possibility that prospective rate setting could have an adverse impact on having adequate or sufficient capital in the system; and also, as suggested by an earlier question, I do have concerns about how these systems permit us to sort out the good from the bad.

So when I get back maybe we can kick off with your reactions to that.

[Whereupon, at 3:15 p.m., the hearing was recessed.]

AFTER RECESS

Senator DURENBERGER. We can proceed. I think I laid out in a general way my concerns.

Mr. Schramm, perhaps you can begin by responding to that from Maryland's perspective.

Mr. SCHRAMM. Senator, regarding the capital question, I thought I would make a couple of observations in Maryland.

First of all, I think it's a critical question. Mr. Derzon said it best. I would point out appendix IV. If there is a blip in the Maryland experience in 1979, it really is because we opened so many new hospital beds. I think the issue boils down to controlling hospital growth and insuring an adequate capital base in hospitals, that is, enough hospitals around to handle the population extant, as well as to make sure there is enough money to rebuild the hospital capital stock.

The problem on the other side is you don't want the industry to get so big that the burden becomes excessive in terms of drawing off resources for other social expenditures and economic investment.

In Maryland we have handled that situation by building into the rate base every year sufficient moneys to recapitalize the industry, so there is a 2-percent grant on the base rates every year for the hospitals to essentially put into the bank for recapitalization.

I think there is one other observation I should make. It regards the ability of hospitals in regulated States to go into the capital market and get private sector funds.

As you know, over the last 10 years the amount of hospital construction financed in the private sector capital market, principally Wall Street bonds, has grown from 5 percent of all hospital construction to almost 75 percent in 10 years. So the predominate fashion or function of financing new capital construction in hospitals is through publicly issued debt instruments.

In the State of Maryland we have enjoyed extremely high ratings on our bonds. Our bonds are issued through a tax-exempt authority, the Health and Higher Education Bonding Authority. The Authority never issues a bond, as the underwriters won't take them,

unless there is a comfort letter from the Commission to insure that revenues sufficient to support the debt service will flow through the life of the obligation.

A number of investment bankers have told the Commission, and they appear before the Commission on motions for comfort letters, that in fact the recent offerings coming from our State have enjoyed higher ratings and lower interest rates because of the comfort or security debt holders feel regarding the role the Cost Review Commission plays in the long-term financial viability of the State's hospitals.

Senator DURENBERGER. Would you care to add to that, Mr. Crane?

Mr. CRANE. Yes. I would just add that the issue of capital is of extreme concern to us. People in New York State are talking about the possibility of trying to determine a capital budget for the State as a whole, and then in essence having hospitals compete one against the other for allocations under that budget. I don't know whether we will get to that point, but that's one of the notions that is being seriously considered.

Clearly, if we are to consider all of the proposed projects that are currently before us, given our current standards in the planning system of absolute need and financial feasibility and other tests, approval is probably indicated. A major teaching hospital in New York City that wants to replace itself at a cost of $½ billion. It is difficult to say that that facility is needed. Whether the modernization to the extent proposed is needed is another question. We need to define and develop a system which helps provide an answer to that.

Senator DURENBERGER. Let me ask you a question which I want to remember to ask the next four panelists also, and which I was reminded of when, I think, Mr. Schramm, you mentioned the school closing example. It seems to me that in an ideal world—my kind of an ideal world—when we are changing from prospective reimbursement to something else which more adequately provides all of the incentives that we want in the system, that we might go to a voucher system. Then you, and you, and you, and everybody gets *x*-number of dollars, and you go out and make the choices. Then the community and the provider react to that by being more efficient and responsive to patient needs. But we are still a long way from that. Prospective reimbursement may be a step in that direction but we have to assure that when we get there there is an adequate choice for people to make.

Now, let me make another observation about what I have been hearing here today. I seem to be hearing a recommendation that we sort of downshift the process of planning from a federally dictated HSA and certificate-of-need process to something in which we rely on States and, using Rochester as an example, local communities to provide us with a more efficient, less costly delivery system.

But I am not sure who, when you downshift, is really making the decisions about quality and cost. I don't know whether it is a bunch of doctors that got together in Rochester and decided, "We want to hang on to our hospitals we had better get all eight of us together," or whether it is some politicians from Maryland who decided, "If we want to save those important inner-city hospitals, we had better

start shifting costs of their service delivery over to other hospitals." I wonder whether, ultimately, we will have a system in which the consumers do play some role.

In the school closure example the consumers really don't have that much of a role. There you have a community saying, "We've only got so many dollars to spend, and such-and-such a population to spend it on, and we are going to close these schools." The individual consumer, the person in need of education or the parent, really has nothing to say about it. They can go and protest at the school board meeting, but they can't use their tax dollars or any other dollars to say, "I offer the way these teachers operate in this setting to the way those teachers operate in that setting." That isn't the way public education works in this country today.

Maybe I am expressing a concern that the provision of health care might run the risk of going the same way as elementary and secondary education, where we just sort of downshift it to a local service delivery system in which the politicians and the community and the doctors get together and say, "We're going to have so many hospitals, and they are going to look like this and charge so much."

Is there any risk of that happening under ratesetting in your two States?

Mr. SCHRAMM. Well, sir, I think there is a very severe risk, and it's the risk I think you feel strongly about. That is, it's a risk to the emergence of a real market system.

I think the approach in Maryland is really a market regulatory approach. We regulate with the idea of establishing incentives in the regulations which will make people behave as if they were in a market.

The real risk is if we continue to permit growth of acute-care institutions, such as Bob has made mention of in New York City.

The commitment to a "star wars" hospital in 1985 largely displaces resources that would be available to develop alternative sources of care. We face that problem in the State of Maryland. Our planning agencies have repeatedly refused licenses to day surgery centers on the grounds that there was redundant capacity in the big acute-care hospital surgical facilities.

So in many respects I think my real fear is, with overcapitalization we essentially put in place political demands and political power groups which will preclude or shut off the ability to generate alternative suppliers of care. I think this will be a particularly acute need in the future with the surplus of physicians coming on board, where I think there is a great promise in terms of all kinds of new ideas that we would like to see generated in our State.

But if the primary demand is in place, and it's larger in terms of the extraordinary political influence of these hospitals, it could foreclose these opportunities. And these are the opportunities, I think, where the real market could emerge in the future.

Senator DURENBERGER. So, in designing a prospective reimbursement system, we have to be especially aware of these kinds of political influences and the pressures that come from a surplus of providers. Is that correct?

Mr. SCHRAMM. Absolutely.

Senator, I have designed some model legislation that is appended for the record, and I think the solution is basically a political one. Legislators or Governors must make a decision, a public decision, concerning the amount of capital that should flow into this industry. And I think it is largely a decision where, in the State of New York, people blame the regulatory agency. It's a larger political decision which, you have observed in many other States, Governors choose to duck behind regulatory agencies.

By and large, it is a full-scale political decision to shut hospitals in the State. It can't be anything but a political decision. And in many cases it devolves to the regulatory agency without proper instruction or education of the body politic.

I think actually what we ought to do is make it very explicit, have the legislature establish the amount of new funds that will flow in the State's economy for construction or replacement of hospital capital, and explicitly announce a certain pool of resources that would be available for funding or financing or capitalizing alternative suppliers of care to the market.

Senator DURENBERGER. Mr. Crane?

Mr. CRANE. In order to have consumers make intelligent choices within a health-care marketplace, were it to develop, they have got to be well informed. And it seems to me that one of the intermediate benefits that you may have by creating some incentives for States to take a major or larger role in this, and to continue and even strengthen the health planning process, is to stimulate that involvement and increase in knowledge of those who participate in the health-planning process.

I think the process itself can go a long way to making consumers more intelligent buyers, which, it seems to me, is a prerequisite for getting where you want to go.

Senator DURENBERGER. Thank you both very much. There are other questions that should be asked, but our time is limited.

Our next panel will be the four remaining panelists: Donald W. Davis, president, Hunterdon Medical Center, Flemington, N.J.; Francis R. Dietz, president, Memorial Hospital, Pawtucket, R.I.; Joseph I. Morris, acting assistant commissioner, health planning and resource development, State Department of Health, Trenton, N.J.; and John Murray, assistant director of administration: planning and financial management, State of Rhode Island, Providence, accompanied by Armand P. Leco, senior vice president, Blue Cross/Blue Shield, Rhode Island.

Senator Bradley said to say hello to Mr. Davis. He will try to get back, but I don't know that he can make it.

Perhaps what I might do is suggest that, since Mr. Davis of New Jersey was first on this list, we might take the two New Jersey examples and talk about them, and then take the Rhode Island example and talk about it. That might help my mind work a little better.

So, if we can start with Mr. Davis.

Is there a preferable way to go, Mr. Morris?

Mr. MORRIS. Mr. Chairman, I'll go first.

Senator DURENBERGER. All right.

STATEMENT OF JOSEPH I. MORRIS, ACTING ASSISTANT COMMISSIONER, HEALTH PLANNING AND RESOURCE DEVELOPMENT, STATE DEPARTMENT OF HEALTH, TRENTON, N.J.

Mr. MORRIS. Thank you very much.

I would like to say that I'm not going to read my formal comments. I would like them entered into the record, but I'm too compassionate to submit the committee and the audience to reading more of the same.

I would like to underscore that I agree with much that my colleagues from the other States have said, especially Dr. Schramm from Maryland. We have borrowed quite a few aspects of the Maryland system for use in New Jersey.

We are very proud of our record of rate control in New Jersey. The Department of Health has been regulating rates since 1975, and the hospitals in New Jersey were doing it for 7 years before that under a voluntary budget-review system.

In listening to some of the discussions that have occurred already today, one thing struck me, especially when I heard of the differences between Rochester and the rest of the State of New York. I think it is something that existed in New Jersey, but we have managed to work it out somewhat.

I think it is necessary for the regulated and the regulators to agree on some common goals and philosophies of what the rate-review system should do. We had a lot of battles when we first established rate regulation in New Jersey. In fact one of my old adversaries, Mr. Jack Owen, president of the New Jersey Hospital Assocation, is at the hearing today. During these battles with the industry, it was very surprising when, with both of us too tired to fight any more, I said to Mr. Owen, "Well, what do you really want?" When he told me, it sounded an awful lot like what we wanted to accomplish, too.

So I think there is a need to have some sort of input by the hospitals to recognize what are the goals and objectives of trying to allocate scarce resources, and do it in a manner that makes sense.

We did have a budget review in place from 1975 to 1979, and it was very much like Maryland's review process. But we saw some shortcomings, and we decided to try to correct those. I think the shortcomings that we saw in our budget system were:

First. We previously covered only Blue Cross, medicaid and local governmental payers and just on the inpatient side. The first thing we wanted to correct was to have all payers participate, and to have both inpatient and outpatient costs covered. The reason for this is that when all payers participate you avoid cost shifting, which you yourself have indicated can be a problem.

Also, the reason that you need to control both inpatient and outpatient reimbursement is that within the whole outpatient area you can develop many alternative delivery modes that you want to encourage. These modes are important, effective, and cost-efficient alternatives to inpatient hospitalization.

The second thing that we wanted to do was to treat hospitals fairly, and that meant a different treatment of hospital financial elements.

As you yourself and Dr. Schramm indicated, the hospitals have to be paid for uncompensated care—that amount of medical indigency that is not picked up by a medicaid or a medical-needy program.

There are also capital needs—for the replacement of the plant, maintenance of equipment and working capital. These are elements that we worked into the New Jersey system.

Then, the thing that makes New Jersey quite unique as a State, besides being squeezed in between Philadelphia and New York, is its approach of setting hospital rates by case mix. It is necessary to have a fair treatment when rates are being set; because when you measure hospitals, how do you know that you are measuring a hospital that does the same amount of tonsillectomies or open-heart surgeries as the one down the street?

I think we saw that need to measure hospitals fairly, because if you are going to set rates on a cost per admission, they had better be for the same types of admissions.

The other thing is to use the case-mix system to really make an impact on the way that care is provided. This system was developed with a lot of input from physicians. I think that that influence is evident in the system and makes it useful because the physician is the true resource consumer in the hospital. The physician admits the patient; he orders all the tests; he controls everything that happens to the patient; and then eventually discharges the patient. Whether it is a long length of stay or a short length of stay, the administrator can't have a very effective control on hospital resources unless the medical staff is working with him and communicates with him.

Given that role of the physician, I think we had to look at how the physician was trained. In medical school the physician is trained to treat each patient as an individual, and that guides his clinical judgments. Each patient is individual. Whereas, rate regulations tend to focus on the average patient consuming the average amount of resources. Each patient day is treated like every other patient day, as are admissions, in terms of the resources used.

What we have attempted to do in New Jersey is to try to come up with a patient classification system that groups similar types of patients together; and, using this type of a system, we think we provide a common language so that the regulator, the hospital administrator, and the physician can talk very meaningfully about efficiencies in the ways of delivering quality care.

What we have used is a system called diagnosis related groups, or DRG's. There are 467 of these groups, and they attempt to classify patients who have similar illnesses and similar treatments. It is based on the physician's own language—the diagnoses that he writes. There are some 13,000 different diagnoses that a physician could write for you. Of course, if we had 13,000 different groups, and if we included all the combinations and permutations occurring when you include secondary diagnoses and a number of procedures we would have an unmanageable number of groups. It's somewhere up in the tens of billions, I think.

So we have taken a system that was developed at Yale University. It contains 467 groups, and that is a manageable number. We think it works pretty well.

First of all, it allows the physician to start to look at types of patients. This is important, because the first thing we do is make cost comparisons, and it had better make clinical sense to the physician or you are not going to go anywhere with it. My colleague Don Davis very well knows that if we had a system that didn't make any sense at all, his medical staff would never listen to him, and he would have to come back to me and tell me that I was out of my mind.

Our system is prospective, and it's incentive-based. We develop a price per case for each one of these DRG's in the hospital, and we will tell a hospital, "Your historic cost is $1,000 for treating this appendectomy. The rest of the hospitals in the State that are similar to you are doing it for $800. So we will pay that hospital approximately $900." So already there is a disincentive if the hospital is inefficient.

Conversely, there is an incentive. If the hospital is treating a certain type of case for $800 and the average cost is about $1,000, we will give it about $900. So there is a reward, and it is prospective. If the hospital can then control its costs during the year and beat the price per case, it gets to keep the difference. This is a point that Mr. Derzon made, that there has to be some way that the hospital can keep the savings of its cost reductions. That does happen in New Jersey.

Now, in addition to setting the price per case, what we also provide to the hospital is a set of management reports. We indicate to the hospital not only where its costs for open heart surgery might be higher than the State average but which departments that happens in. Is it laboratory? Operating room? Nursing? And with this information the hospital can work with the physician, the true resource consumer, to try to determine how care is delivered and how to better deliver care.

What we think this system does is to bring market forces to bear on hospital decisionmaking. The hospital will be paid a fair price, and then it will have the means to determine what it is that it must do to achieve efficiencies.

I would like to just briefly give a few examples of some of the things that we do with the New Jersey system, even though the bell is going to ring on me.

We have one hospital that does a lot of open heart surgery, and it never knew exactly how much those cases cost. We actually price out each case. When the hospital saw the high amount of money that each case cost, it was so surprised it decided to dig further into the management reports. It saw that it was spending quite a lot of money on something called a blood-gas test. So it went to the director of the unit and said, "Why do we do so many blood-gas tests?" The director of the unit said, "Well, that was a standing order we developed when we set up the unit some 5 years ago, and we just never thought to review it." So they did a medical audit of charts over a period of 3 years, and they determined that they could change the standing orders. That hospital now uses 50 percent fewer blood-gas tests.

Another example which is probably the most telling involves the DRG for pacemaker implantation. The medical director of one hospital was looking at his costs in that, DRG and he had a higher

average cost than other hospitals by some $2,000. So he went to the management reports to see where it was that he was high. His hospital was high in an area called medical-surgical supplies. The highest cost item was the pacemaker itself. When he looked into the facts of the matter, he saw that there were a great number of pacemakers being used in the hospital. When he did a study to determine how the surgeons were using pacemakers he found that each surgeon had his own favorite; there was no real trend. Although there were differences between the pacemakers, the surgeons seemed to go with their own favorite brands.

When he confronted the surgeons with it, they said, "Well, the detail man came in, and we just went with his spiel." They got the surgeons together and developed criteria to show which pacemakers made sense for which patients. Some pacemakers are good for 14 years; others for 5 years. Obviously, if you have a 50-year-old patient you want to use the 14-year pacemaker.

The other important thing they found was that prices ranged very dramatically, even for comparable equipment. The surgeons then worked up the criteria. They put it over the table where they order the pacemakers, and they included the price of each pacemaker. After a short period of time the surgeons started using more appropriate pacemakers for their patients; there was a cost savings, and the biggest cost saving wasn't even clinical. The detail man for one of the highest priced pacemakers came in; he looked up and saw the price of his pacemaker listed there—at the top of the hit parade; and he said, "What the dickens is that price doing up there?" When it was explained to him, he went out and made one phone call, and he came back with a sweet deal. As long as the hospital didn't tell anybody else, he was going to drop the price of pacemakers $1,000 per unit.

I think this underscores the linkage of a clinical system with the reimbursement system. You have to somehow be able to have the doctors step back from the bedside and review care and how they provide it; instead of thinking of individual patients, think of patient types.

The other thing we do, in response to your question, is we have a very active program of health planning and certificate of need to try to control the capital costs and to make sure that only the needed facilities are built and are reimbursed. We think that this type of prospective reimbursement system goes hand in hand with an active health-planning program and with utilization review.

We work with the New Jersey PSRO's, and I'm happy to say that the Federal Government has been participating with the Department to really change the review system and criteria to make them fit with our prospective reimbursement system.

In New Jersey, health planning, utilization review, and rate review are all within the same division under me in the Department of Health.

In summary, we have had some degree of success with this program. I could cite the statistics, but then other people cite other statistics. But just in 1981 the 26 hospitals that came on the system in 1980 had a cost increase of about 15 percent while national increases were about 18.7 percent. Just for the State of New Jersey that approximates almost $90 million in savings.

97-561 O - 82 - 12

With that, I will conclude my remarks and be willing to answer any questions you may have, sir.

[The prepared statement of Dr. Shirley A. Mayer and Joseph I. Morris and answers to questions from Senator Durenberger follow:]

STATEMENT ON PROSPECTIVE REIMBURSEMENT SYSTEMS

Before the Subcommittee

on Health

United States Senate Committee on Finance

by

Shirley A. Mayer, M.D., M.P.H.
State Commissioner of Health

and

Joseph I. Morris
Acting Assistant Commissioner
Health Planning and Resources Development

New Jersey State Department of Health
CN 360
Trenton, New Jersey 08625

June 22, 1982

Mr. Chairman, members of the committee, my name is Joseph I. Morris. I am the Acting Assistant Commissioner for Health Planning and Resources Development of the New Jersey State Department of Health. I have the day-to-day responsibility for running the cost containment system and the health planning and Certificate of Need process in New Jersey. I will make my statement and answer any questions you might have.

Mr. Chairman, you and your colleagues on this committee are faced with an enormous task, one on which the future well-being of literally millions of Americans will depend. In this age of dwindling health resources, it is imperative that health care services be provided in the most efficient and effective manner possible. But cost containment efforts, if undertaken in haste and without adequate foresight, can substantially impair the ability of many of our sickest and most truly needy citizens to receive vitally necessary health services, and substantially damage, if not destroy, many of our most valued social institutions, such as urban hospitals, medical school teaching hospitals, and certainly public hospitals, as well as some rural hospitals that serve many of the poor.

Mr. Chairman, if you wish to reduce the costs of health programs, you can do so either by reducing services or by reducing what you pay for each unit of service. An arbitrary cap or limitation on aggregate Medicare expenditures will lead to substantial reductions in services to the poor and the elderly. That seems the simplest and most direct solution administratively, and some may believe it to be the easiest solution politically. But our experience in New Jersey, and that in some of our sister states, suggests that a well thought-out and well managed system for controlling the reimbursement rates paid to the providers of services can insure program economy without reducing access to necessary services. Further, we are beginning to learn in New Jersey, as has been previously demonstrated in Maryland, that well-conceived state programs to regulate hospital costs can effect considerable savings. Such programs are being implemented without serious restrictions on the availability of service or the financial viability of the providers of care, and indeed can even do much to improve the financial status of well-managed institutions which serve a disproportionately large number of poor citizens.

If one has to choose between reducing the supply of services or reducing their unit cost as a strategy for cost containment, it is desirable to look at the actual record as to what has happened under prospective hospital reimbursement systems. Indeed, analysis after analysis has shown that over the last decade, only a small fraction of the total increase in health care costs can be attributed to increased utilization by any part of the population. By far the greatest proportion of

cost increases have come from increases in the unit price of a patient day or an outpatient visit, along with some increase in the "intensity" of the services provided.

On the other hand, the evidence on controlling the rate of increases in prices in the hospital sector in those states with mandatory cost containment programs is clear and encouraging. Federal expenditures for hospital care, primarily of course under Medicare, are so enormous, and growing so rapidly, that relatively modest proportional inroads into that growth can generate sizable economies. Under current projections, Medicare expenditures for hospital care will increase anywhere from 15 to 20%, or five to six billion dollars, in the next fiscal year. The increase in health care costs over the last decade has consistently exceeded that in all other sectors except energy and more recently, housing, and has thus been a major contributing source to the inflationary spiral.

Effective systems of hospital rate or budget control, save not only government dollars but private dollars as well, and therefore contribute to control of inflation not only through a reduction in government expenditures, but also through a reduction in private expenditures.

The General Accounting Office concluded that mandatory state hospital rate setting programs reduce hospital expenditures approximately 4% below states without mandatory programs. That figure is based not on some theoretical model, but on the actual experience of such programs in the period up through 1978, and there

is further reason to believe that the pay-offs from such programs have increased since then.

And we do know how to control hospital expenditures. Such controls are achievable, on the basis of the evidence in Maryland and New Jersey, and analogous evidence from other states. State rate setting systems which control total hospital expenditures have moderated the growth of hospital costs for all payors. However self-serving that conclusion might sound, I should also emphasize to you that it is not solely our own. Indeed, it is a conclusion that has been arrived at independently by the General Accounting Office, the Congressional Budget Office, and a much discussed article in the New England Journal of Medicine, all of which concluded that it would be desirable to expand such rate setting authorities to other states.

State hospital rate setting programs in which all payors participate have another significant characteristic. Rather than weakening the financial status of those who provide services to the poor, they can substantially improve them when all payors participate and share among themselves the costs of services to the medically indigent. Indeed, in essence, rate setting systems such as those in Maryland or New Jersey are able to save enough payor dollars to provide adequate revenues to hospitals serving substantial numbers of the medically indigent, and still return a savings dividend to those payors.

To recount some of the specifics of the New Jersey experience, in 1980 we implemented our hospital rate setting demonstration, which under a planned phase-in involved a sample of 26 hospitals. During 1980, the rate of total hospital cost increase for those 26 hospitals was held to two to three percent below the national average, while recognizing for the first time as reimbursable costs services to the medically indigent. We also provided what we call a "working cash infusion," a direct infusion of reimbursement cash, to hospitals which, because of an historic role of providing services to the poor, entered the system with significant working capital deficiencies. Among the 26 hospitals, the working cash infusion exceeded $4 million. In other words, even while picking up costs to the services to the poor that had been met in the past only by the liquidation of hospital endowments, the liquidation of hospital capital, or the failure of hospitals to pay their bills, we still saved Medicare between $5 and $10 million relative to what it could have been expected to spend had its costs increased at the national rate. $5 million, of course, is not a very large amount compared to total Medicare expenditures, but remember that we are talking about only 26 hospitals, and only about the first year's experience when there were significant one-time start up costs which we anticipated and planned for from the outset. The preliminary results for calendar year 1981 indicate an increase of approximately 15% for these first 26 hospitals while the national increase was 18%.

Again, I must emphasize that we have accomplished these savings without deleterious financial impact on inner city or rural hospitals, and with, as far as we have been able to discern,

improved access to hospital care for the poor and medically indigent. Nor is there the slightest evidence that the quality of medical care in hospitals engaged in our rate setting demonstration has suffered to any degree. Indeed, we have considerable evidence that in many specific instances our program provided the vehicle for significant quality improvements.

As you know, Mr. Chairman, the new hospital rate setting system in New Jersey, building on our earlier system in which we regulated only the rates paid by Blue Cross and Medicaid and other governmental entities, involves the innovative and much discussed methodology of payment by the case rather than the day, on the basis of diagnosis related groups, or as they are commonly called, DRGs. We think case-mix related reimbursement on the basis of DRGs is an excellent means of hospital reimbursement, and one that holds considerable promise not only in New Jersey but for the rest of the nation. But what should be emphasized for our purposes here is that any of a number of technical methodologies might well be capable of achieving the same general results. Whether the system is based on prospective revenue controls, prospective budget review, DRGs, or any of a number of other technical approaches, the basic finding of the GAO, the CBO, and others is that, when well managed, they all seem to work. It just appears that in an industry where the rate of cost increase has exceeded the rate of increase in input prices by fifty to one hundred percent every year for more than a decade, it is not technically difficult to achieve improved efficiency.

The advantage of the case mix approach is the linkage of reimbursement with the clinical practice of the provider (both hospital and physician). The 467 DRGs are a set of medically meaningful and statistically stable diagnostic groups which permit comparisons among like cases in hospital care. DRGs provide for reimbursement on the basis of the case, rather than the day. They also permit more effective communication among regulators, administrators, and physicians about the economy, efficiency, and, most importantly, quality of care compared across hospitals.

In addition to the advantages of per case payment versus per diem payments (which can provide perverse incentives to lengthen rather than shorten length of stay), the New Jersey system has two other distinct advantages. The first is the provision of equity among all payors to share in the total hospital financial elements such as uncompensated care, replacemnt of plant and equipment and working capital needs.

The second advantage is that the system is prospective and incentive based. Hospitals receive a financial incentive to be efficient and a disincentive if they cannot control expenditures. A price per DRG is established based on its actual cost of care and the comparison of the statewide average cost for that type of care. For instance, if a hospital spends $1,000 for a normal delivery while the average cost in the state is $800, the hospital will receive a payment rate of approximately $900 per case. The Department also provides management reports which will show the hospital which departments are inefficient (such as laboratory, radiology, nursing, etc.).

Such an approach introduces to hospitals the natural competitive market forces which other industries operate under. They will receive only a "fair" market price and they will know in what areas corrective action must be initiated. We have even seen evidence that based on this management information, hospitals can reduce their expenditures and even beat the price per case and make a surplus on these cases. It is even possible for the hospital to extend the management reports to compare the practice of the physicians on staff.

While there is considerable debate about the introduction of a competitive market for hospitals, it is important to consider that in many areas of our country there is no competition for the county hospital. In a situation where there is only one hospital in a wide geographical area, how could you introduce competition? The approach of New Jersey could be employed using the cost comparisons of similar rural hospitals with similar mix of patients. Additionally, the system allows the hospital to compete with itself through the use of the management reports. Previously this information was not available and the use of these reports allow providers to review their practice from a distance rather than at the bedside.

Historically, physicians have been trained to treat each patient as an individual case and as such the emphasis is to be at the bedside ordering whatever test or treatment. This system allows the physician to reflect on his practice on types of patients when he is away from the patient's bedside.

The emphasis of this system is clinical and on the quality of care. In this vein, I should mention that the Hospital Rate Setting Commission has enlisted the aid of the Commissioner's Physicians Advisory Committee. The committee will help the Commission in its evaluation of innovations in medicine so that a reimbursement rate for a particular DRG does not prohibit the proper advancement of modern medicine. This is very important. In no way should any rate setting system interfere with sound medical advancements which improve patient care, treatment or diagnosis.

However, one does not implement such a radical and innovative program without experiencing some problems and criticisms. The initial set of DRGs were an important first step in linking a clinical system and a payment system and some unusual results popped out. The most notorious was the case of the $5,000 finger, in which a patient had an accident with a softball and damaged his finger so badly he was hospitalized for two days so that the bone could be repaired with a metal pin. This case (which is rather unusual) was assigned to the DRG for major hip repair and hence the cost of $5,000. The Department of Health responded quickly to correct the patient classification system to account for these unexpected results. The Department worked with Yale University to completely redesign the DRGs and this new group of DRGs are much more clinically meaningful and have been implemented in New Jersey.

We have also noticed some concern with the unwanted incentives introduced by a per case payment system. There is the notion that the system will encourage an increase in unnecessary admissions or unjustified diagnoses (labelled DRG creep). The Department is working with peer review groups (including the New Jersey Professional Standards Review Organizations) to monitor if such behavior exists. Our conclusion to date is that this is not a problem due to the professionalism of both physicians and medical records personnel.

I would also like to suggest to you that our experience, at least in New Jersey, suggests very strongly that health planning and some system of professional peer review are essential and effective complementary tools to hospital rate setting programs. They work best in an environment in which rate setting, quality assurance, and planning, including capital expenditure controls, are integrated in a single agency, as they are in the New Jersey State Department of Health. I wish to emphasize that if we are to save federal budgetary dollars in the health care sector, most of those dollars are in the Medicare program. If we are to save Medicare dollars, then our best hope is for a combination of effective rate control and capital expenditures control programs. The increasing body of evidence is that such programs work. The alternative, in the long run, is reducing the benefits available to Medicare recipients, which would involve the breach of a very basic and fundamental commitment that has been maintained by the Congress and five Presidential Administrations over the last 15 years. The best way to control Medicare expenditures we have

available is state operated rate setting programs that cover all payors in conjunction with vigorous planning and quality assurance activities.

In summary, Mr. Chairman, the technical means are at hand to achieve very substantial savings in health care expenditures. The use of mandatory prospective rate review systems can achieve savings in hospital expenditures without sacrificing quality. The use of a case-mix approach such as New Jersey's DRG system can even enhance quality while at the same time achieving significant savings. We even expect greater savings when we can intergrate DRGs with health planning to study the delivery of care and develop alternative delivery modes which will allow for savings and a renewed attention to preventive care.

I am most grateful for the opportunity to appear before you today. I would, of course, be happy to answer any questions you might have.

JOSEPH I. MORRIS' ANSWERS TO QUESTIONS SUBMITTED BY SENATOR DURENBERGER

Question. What is the role of health planning and utilization review in a prospective ratesetting system?

Answer. Utilization review has a two-fold function within such a rate system. First, it can be used to plug the loopholes in such a system. For instance, prospective systems that prescribe a per diem rate may encourage perverse institutional behavior in the form of excessive lengths of stay. Prospective systems, like New Jersey's, which are based on some form of price per case or admission may encourage unnecessary admissions or readmissions. Effective utilization review can counteract such undesirable behavior. Utilization review can foster hospital efficiency when it focuses on the unnecessary (excessive) use of diagnostic and/or therapeutic ancillary services within the institution. The second role of utilization review is to ensure that patients are not discharged too early, and that they are not unnecessarily subjected to risky diagnostic and/or therapeutic procedures: in other words, more of a purely quality assurance function. Of course, such a distinction between cost control and quality assurance functions is in many cases artificial: good quality care may in fact cost less. Finally, we should note that questions about the cost effectiveness of utilization review might be resolved in efforts were made to have such review done with a narrower focus but with greater effectiveness. Identifying potential quality problems and focusing review to establish the existence of and remedies for these problems should be a key part of UR efforts. We are working with the PSRO's in New Jersey to do this.

Health planning also continues to have an important role in the context of a prospective reimbursement system. Any regulatory approach to reimbursement must face the issues of what financial elements in general should be covered in the rates, and what new components of the accepted financial elements should be covered. In other words, what generic types of costs will be allowed in the rates which are set, and what new elements of these costs will be allowed: new services, new buildings, new types of equipment. Decisions on which specific new items of cost will be reimbursed have to be based on a rational but flexible process of choice: i.e. a planning process. Some mix of publicly-oriented planning and private planning is necessary to ensure (1) that reimbursement is for medically necessary services, buildings, and equipment, and (2) that the institution-specific concerns addressed by institutional or multi-institutional planning are tempered by a broader view of regional or areawide needs.

I should add that clinically-oriented prospective ratesetting systems like the one we have in New Jersey may help to make planning more flexible and rooted in actual experience. James Greenberg and Roger Kropf have shown how case-mix methods can actually be used in planning in the November 1981 issue of Medical Care, a health care journal.

In summary, utilization review and health planning activities continue to be essential as part of a prospective rate-setting system, and can be made more effective by the information generated in the rate-setting process itself.

Question. Should the rates established under a prospective rate-setting system be mandated only for medicare and/or other federally funded users of health care, or should they be applied to other types of patients?

Answer. As recent studies by the Congressional Budget Office have indicated, the answer to this question depends on one's view of the cost/shifting issue, and on one's concern for increases in the total costs of the health care system, rather than only the share of the government's cost.

Cost-shifting, in its simplest form, occurs when hospitals shift costs of care which are not covered by certain third party payors onto patients whose third party insurers will pay all or more of these costs, and onto self-pay patients. This occurs because some payors (Medicare, Medicaid, Blue Cross) make payments on the basis of reasonable costs, while commercial payors and self-pay patients pay on the basis of actual charges to the patient. Cost-shifting enables those hospitals with sufficient numbers of charge-based and non-indigent payors to avoid some of the hard decisions about institutional management, patient management, and resource allocation which the revenue restrictions imposed by cost-based payment would normally require.

Is cost-shifting justifiable? Some policy analysts would note that the costs not covered by cost-based payors are in fact unnecessarily incurred by the hospital; that commercial payors could refuse to cover these costs by changes in the health insurance policies which they issue; and that the ability of hospitals to shift costs is limited by the potential or actual resistance of self-pay and commercially insured patients to excessive increases in charges. The latter argument presumes that these

payors can always shop around for more reasonably priced care and that such "shopping around" can and will be done regardless of the patient's illness state at the time of a hospital admission. It also presumes that commercial payors will be willing to alienate subscribers by telling them which hospitals and (depending on the pattern of admitting privileges in an area's network of hospitals), which physicians to use. In the case of inner city hospitals, which cannot shift costs, the hospital is punished not only for possible inefficiencies, but also for having to serve indigent patients. So cost shifting may be justified as a rather indirect approach to controlling the increase in the total costs of hospital-based health care. However, it is a blunt tool, and one with extremely uneven and difficult to calculate effects.

Whether Medicare moves to some form of prospective reimbursement or retains its current cost-based system, the questions concerning cost-shifting remain the same. As long as the costs of some payors are controlled, and those of other payors are not, the brake on total health care system cost increases is achieved in part by regulation, and in part by demand-side market effects: i.e. charge-paying commercial patients and self pay patients are induced by excessive charge increases to shop around for cheaper care, or are induced to make sure that less care is consumed. Whether such a demand-side effect will occur, and whether it is equitable to shift such responsibility for controlling health care costs onto a relatively circumscribed group of consumers, are questions which have to be answered. If the costs of all payors are controlled, and the regulatory approach is used for all hospital care consumers, then there is more likelihood of total costs being constrained. The problems with this approach are: (1) it is likely to summon up more determined opposition from key components of the hospital industry; (2) to obtain industry consent for such a scheme, allowable costs would probably have to include costs of financial elements hitherto uncovered by cost-based payors; (3) the success of the system would require integrated and vigorous efforts at health planning and utilization review to ensure that hospitals are not evading the legislated controls.

In summary: Whenever hospital care costs are controlled by regulatory methods for some payors, and by market dynamics for other payors, some amount of cost-shifting is likely to occur. Whether controls are a function of cost-based payment systems, or prospective rate systems, the cost-shifting effects will follow. If a concern of federal policy is not simply the limitation in the federal share of rising health care costs, but a limitation in the rise in total national health expenditures, then serious consideration must be given to whether a combination of regulation and cost-shifting, or a more thoroughly regulatory approach, is the best way of achieving those ends. The mixed approach is easier to implement, but has an unpredictable impact, and suffers from an insensitivity to some equity considerations. The more regulatory approach is harder to win assent for, requires more vigilance, but is more certain in its long range effects on unnecessary health care cost increases.

Question. Which health care services delivered in the hospital setting should be covered under prospective rate system?

Answer. Should prospectively set rates cover only inpatient care, or outpatient and inpatient care? Our feeling is that both types of costs should be covered. First, if only inpatient costs are controlled, hospitals might try to shift their actual costs onto outpatients through an increase in outpatient charges. Instead of trying to manage themselves more efficiently, hospitals would simply try to shift costs from one service to another. Second, by adjusting rates for outpatient services, incentives can be created to encourage the use of less expensive outpatient delivery modes rather than inpatient services. Control over the full range of a hospital's direct patient care costs can help insure the integrity of a rate-setting system, and to encourage the use by patients of less expensive outpatient services.

Senator DURENBERGER. Mr. Davis?

STATEMENT OF DONALD W. DAVIS, PRESIDENT, HUNTERDON MEDICAL CENTER, FLEMINGTON, N.J.

Mr. DAVIS. Thank you, Senator.

I am very pleased to present some comments as a hospital administrator living under a mandatory rate-review system.

I think that I would agree with Mr. Morris on a couple of points, and probably take issue with some of the statements that he has made.

First of all, I would indicate that I think the legislation creating the rate-setting system in New Jersey contains some very positive features that I strongly support, and Mr. Morris has indicated a number of those.

One is that the financial solvency of institutions should be maintained, which I think is an important concept to recognize.

Second, that the system is applicable to all categories of payers, which essentially means that isolated decisions on behalf of one category of payer do not adversely affect other categories or the hospital.

Third, there are very important financial elements that are called for in the law which recognize reasonable operating expenses, equipment and facility replacement, bad debts and charity allowances, and working capital.

Fourth, the system is prospective in nature. And again, I think that is very important to the future of rate-setting in New Jersey.

One point not included in the law, but I think it is very important to the process of the regulation, is the spirit with which the rate-setting commission approaches its task. And in general, I think the rate-setting commission in New Jersey initially would get high marks in terms of their responsiveness.

Where I would take exception to Mr. Morris is in the question of whether the system is truly prospective. I would not consider it to be prospective at this point.

Hunterdon Medical Center, where I am, has been under the system now for 3 years. In 1980, our rates became effective in May. In 1981, they became effective in April, and in 1982, they became effective on June 1. In addition to some delays in issuing rates, there have been mid-year adjustments. Appeals are generally not resolved until the second half of the year, and we have had a final reconciliation process that has been completed for only 3 of the first 26 hospitals that entered this system in 1980.

The result is that we do not know in advance the reimbursement that we are going to receive for the year and consequently have difficulty in setting the objectives to manage our institution within those resources.

So I think I would take some issue with that with Mr. Morris, because that is a very important feature.

I think the second point that I would like to make concerns the complexity of the system. Obviously everyone is interested in something that is fair and reasonable; but I think we have to be concerned that, in designing a system that is intended to be fair and reasonable, we don't get it so complex that the management in the institution becomes management of the system rather than management of the hospital.

In New Jersey we have a complicated system involving case mix. I think the case mix has some very positive features, but it does complicate the reimbursement. I think it has added to the expense of the system in New Jersey.

A final point that I would make has to do with the need to tie into the rate-setting process decisions of the planning process and licensure kinds of requirements.

In our own case in the past year, the certificate-of-need which was received for a CT head scanner, after about 8 months of review

at seven different levels within the State, resulted in us acquiring that equipment in November of 1981. However, at the present time the only way the costs associated with that can be built into future rates is through appeal to the commission. We have undertaken that process for 1982, but again I do not expect that we will receive a decision on that before the second half of this year.

I think those are the major comments I would make relative to my support for the positive features of the system in New Jersey and some of what I think have been the drawbacks in terms of the implementation of some very fine legislation.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Donald W. Davis and answers to questions from Senator Durenberger follow:]

TESTIMONY BEFORE THE HEALTH SUBCOMMITTEE
OF THE SENATE FINANCE COMMITTEE
ON JUNE 23, 1982

Mr. Chairman and members of the Subcommittee, I am Donald W. Davis, President of Hunterdon Medical Center, located in Flemington, New Jersey. I welcome the opportunity to offer comments on the matter of state rate review.

Hunterdon Medical Center is a 200 bed, non profit, community hospital serving approximately 90,000 people in a growing county in the western part of the State. Since its beginning in the early 1950's, the Medical Center has emphasized primary care and community health services. Forty percent of the current Active Medical Staff are board certified or eligible family physicians. Physicians practicing family medicine, internal medicine, pediatrics, and obstetrics and gynecology represent approximately 60% of the Active Medical Staff.

The Medical Center operates with 2.3 beds per thousand population and both admissions per thousand and patient day per thousand have been consistently below nation and state averages. The Medical Center provides a full range of primary and secondary hospital services but refers almost all tertiary care to other physicians and medical centers.

Personnel involved in community health services, those

beyond the normal scope of hospital outpatient services, total 60 individuals and represents about 7.5% of our total work force.

The Medical Center is a teaching institution affiliated with the University of Medicine and Dentistry of New Jersey - Rutgers Medical School. We offer a highly successful Family Practice Residency Training Program, one of the first 6 accreditated programs in the nation.

My purpose today is to present those features which I feel must be a part of a sound and responsive rate review system. I will also present what I have seen as some of the problems associated with such programs. My comments obviously reflect experiences in New Jersey. I will leave to those more knowledgeable than I the debate over whether hospital expenditures in states with rate review systems are more effectively controlled and contained than in those states without such systems. However, the results of a recent study quoted in "Hospitals" magazine (April 16, 1982) indicate that the average annual growth rate in non-controlled states in 1980 was 13.7% compared to 13.6% in states with mandatory controls. The margin between the two groups has consistently narrowed since a 4.3% spread in 1978.

The first statewide system of rate review in New Jersey began in late 1960's. This was a voluntary peer review program organized through the New Jersey Hospital Association. Reimbursement decisions covered Blue Cross patients only and were binding upon the hospitals. In 1971, the New Jersey State Department of Health took over rate review for Blue Cross and Medicaid and developed a system known as SHARE (Standardized

Hospital Accounting and Rate Evaluation). This was a per diem reimbursement system utilizing cost comparisons between peer group hospitals to determine allowable costs.

In 1978 legislation was passed establishing a State Rate Setting Commission with authority over the hospital's cost base, revenue base and schedule of rates, or charges, to patients. The law extended the state's authority and supervision of hospital rates to all categories of payors, including Blue Cross, Medicare, Medicaid, commercial insurance and self pay patients. Medicare's participation was accomplished through a waiver agreement between the Department of Health and Human Services and the State of New Jersey.

Certain aspects of this 1978 New Jersey law provide examples of what I consider to be the positive aspects of state rate review. First, the law specifically requires that the financial solvency of hospitals in the State of New Jersey be maintained. This is an extremely important acknowledgement that governmental authority to control costs must be balanced with a responsibility to assure that well-managed hospitals have the financial resources necessary to fulfill their responsibilities to provide quality health care services.

Second, the system is applicable to all categories of payors. This means there is one set of reimbursement rules rather than several. This simplifies management a great deal. In 1979 when Medicare ruled that it would pay only that portion of hospital malpractice insurance premiums which related to malpractice claims paid to Medicare patients, hospitals found it necessary to seek

new arrangements with each other category of payor. In New Jersey, that type of isolated reimbursement decision can no longer be made without regard to all other categories of payors.

Third, financial elements important to the operation of the hospital are recognized in the Law. These elements include reasonable operating expenses, equipment and facility replacement costs, bad debts and charity allowances, and working capital requirements. For example, the law recognizes the costs of indigent care and requires all categories of payors must participate in, and cover the total cost of legitimate indigent care and bad debts.

Fourth, rates are to be prospectively determined. Hospitals are suppose to be issued rates in advance so they can estimate their total revenues and manage their institution's programs and services within those resources. An incentive is provided to hold down costs under this system and an opportunity is provided to any institution which can operate at costs below the rates paid.

Finally, there must be a spirit of trust and cooperation among the rate setters and the hospitals. The attitude of individuals who serve on the Rate Setting Commission in New Jersey has been positive. They have demonstrated their interest, responsiveness and desire to work with health care administrators in establishing a balance between the goal for quality health care services and the need to contain costs.

I consider these features to be essential to a successful rate review program. The rate review law in New Jersey incorporates these positive features. However, the implementation of this law has resulted in several problems which undermine its effectiveness.

First, the rate review system in New Jersey has not been prospective. Hunterdon Medical Center was one of the first group of hospitals to be included under the new reimbursement system beginning in 1980. We did not receive our rates for the year 1980 until January 11, 1980 and they became effective on May 1, 1980. Our rates for 1981 were issued on March 16, 1981 and became effective on April 1, 1981. For 1982 rates were issued on February 18, 1982 and became effective on June 1, 1982.

In addition to the delays in issuing rates, changes in the reimbursment methodology resulted in mid year adjustments to our rates. Appeal items generally have not been resolved until the second half of the year and in many cases during November and December. The final reconciliation process for the year 1980 has been completed for only 3 of the first 26 hospitals included in the system. Hunterdon Medical Center recently completed that process and is due additional reimbursement, which we are authorized to collect in charges to future patients. This recovery will extend until May, 1983. Thus, it will have taken more than two additional years for us to receive full payment for services rendered to patients in 1980. The other 23 hospitals under this system in 1980 are still awaiting a final reconciliation.

The system in New Jersey is new and some initial start up problems and delays were to be expected. However, the current backlog of unissued rates, unresolved appeals, and unsettled final reconciliations makes it extremely unlikely that the system can be prospective in the foreseeable future in my opinion.

The result is a continued uncertainty about our allowable revenues and no clear objectives upon which management can focus its efforts. It has been normal for Hunterdon Medical Center to develop operating and capital budgets in September for the year beginning the following January. In 1981, I suspended the budgeting process as there was little sense in adopting a 1982 expense budget without knowledge of 1982 revenues. Only when our 1982 rates were received did we finalize operating and capital budgets. Without a prospective system of reimbursement and rate review, management simply can not effectively establish goals and direction for the organization. The organization finds itself reacting rather than anticipating and planning for the future.

Because the system in New Jersey has not been prospective it is difficult to interpret how the question of incentives ultimately will be handled. If rates are constantly being recalculated it is very likely that the institution which operated below its allowable costs in one year will find that rates in the following year have been reduced accordingly. The incentives to hold down costs become very short lived and almost certainly indicate that any gains either will be held or used for non-recurring types of expenses. To do otherwise almost certainly means the hospital is forced into the position of appealing future rates. Incentives, to be effective, must assure long term rewards to those institutions which are effectively managed.

The second disadvantage of the rate review system is its complexity. In an effort to assure reasonable and fair reimbursement we continually try to recognize and resolve the

differences between institution and patients. Thus, reimbursement is categorized according to the size of the hospital, its facilities, the types of services and its status as a major teaching, minor teaching or non-teaching hospital. We establish peer group cost comparisons by department and by cost center within departments. The system in New Jersey also tries to recognize the differences in case mix, that is, the types of patients treated at one hospital versus another, through a reimbursement system based upon diagnosis related groups.

Each refinement in the reimbursement system offers the promise of correcting an identified inequity. It also adds to the complexity and expense of the reimbursement system. The more complex the system the more time we seem to spend in managing the system rather than the hospital. Each refinement seems to lead to more management at the state level and less within the local community and hospital. Each refinement seems to foster more dependency on the system and change becomes more difficult and time consuming. Hunterdon Medical Center was awarded $60,000 by the Rate Setting Commission to cover the initial costs of implementing the system. The first 26 hospitals were granted $3,100,000 in total to implement and comply with the requirements of the system for reporting and analysis.

A further complicating factor is the high turnover of personnel at the Department of Health. These personnel calculate the initial rates, perform analyses and make recommendations to the Rate Setting Commission. The increasing complexity of the reimbursement system requires a stable, knowledgeable and experienced staff within the Department of Health.

Each hospital seeks reasonable and fair reimbursement. However, every change in the system must be weighed against its real cost and the reality that no system can be expected to fully account for the differences between 118 hospitals in New Jersey and the variations in the care required by hundreds of thousands of individual patients.

A third major difficulty with our state rate review is the failure to coordinate rate setting, planning and licensure. In October, 1980 Hunterdon Medical Center submitted a certificate of need application for a CT head only scanner. After review at seven different levels approval was granted on June 11, 1981. The equipment was installed in November, 1981. Our estimated 1982 operating expense to provide this service is $73,500. The only way these funds can be included in our allowable rates is through appeal to the Rate Setting Commission. We have begun that process but do not expect an answer until this Fall.

In summary, state rate review systems clearly address the issues of cost containment and accountability for the expenditure of public dollars. Their effectiveness in terms of cost containment has recently been questioned in a study comparing hospital cost increases in states with rate controls versus those states without controls.

Rate review should have long term goals aimed at the quality of health care services provided as well as the dollars spent. A system that acknowledges the importance of the hospital's financial solvency, creates a single system applicable to all payors,

recognizes important financial elements and requirements, creates incentives for effective management and is prospective can be successful. Too often, the system falls behind and becomes retrospective rather than prospective. In an effort to assure reasonable and fair reimbursement it becomes overly complicated, expensive, and slow to adapt to change. Long term incentives for efficient management are often compromised for short term dollar savings. Licensure requirements and the planning agency decisions are not integrated and coordinated with the rate review process. The system of rate review which began in New Jersey in 1980 has both positive and negative features. It is probably too soon to tell which will prevail.

I appreciate the opportunity to make some of my views known to the Subcommittee and would welcome further inquiry and discussion.

August 14, 1982

Mr. Robert Lighthizer
Chief Counsel
Committee on Finance
Room 2227
Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Lighthizer

The following are my responses for the record to questions submitted to me by the Senate Finance Committee's health subcommittee following my testimony before the subcommittee on the issue of state rate review.

1. "Do you believe that a case-mix system as in New Jersey can be implemented on a federal level?"

It is my opinion that the case-mix reimbursement system in New Jersey cannot be implemented on a federal level. The effectiveness of the DRG system in New Jersey as a reimbursement mechanism is still being debated and it is probably too soon to draw conclusions. The system is complex, costly to implement, and requires sophisticated computer support. In my opinion, implementation of the case-mix system in New Jersey on a national basis would place a tremendous burden on the smaller hospitals in this country.

The DRG system is intended to accurately classify inpatients into medically meaningful groups which also reflects the costs and resources required for the care of that patient. In the New Jersey system, cases which do not appear to fit the DRG system are excluded and called "outliers". Outliers are reimbursed on the basis of billed charges rather than a rate per case. Hunterdon Medical Center, which is a 200-bed hospital, with approximately 8,000 admissions per year, expects about 40 per cent of its inpatient cases in 1982 will fall into the category of an outlier.

The system's complexity and cost are also a problem. In New Jersey, the cost of implementing the program in 1980 for 26 hospitals was approximately $3.1 million. Although some of this cost was associated with the initial startup of the program, it is my opinion that each of the hospitals affected by this program have continued to incur additional operating expenses.

2. "How would you compare your state's case-mix system to its previous Standard Hospital Accounting and Rate Evaluation system?"

The Standardized Hospital Accounting and Rate Evaluation (SHARE) system was a per diem reimbursement system utilizing cost comparisons between peer group hospitals to determine allowable costs. Comparisions were made in each of 30 categories of expense. The hospital was paid its actual costs or the limitation in each category, whichever was less. Any reduction in costs in one year meant lower reimbursement in the following year. Under the SHARE system, it was difficult to substitute the costs in one department for those in another department without significant penalty.

Under the DRG system in New Jersey, a rate per case is established. Management is permitted more freedom to decide how much expense to incur in each department or service. If a hospital's direct costs are under the rate paid, it is allowed to keep the difference. An incentive to reduce costs is clearly present.

In my opinion, the DRG system is far more complicated that the SHARE system and requires extensive time and cost to administer. It is also important to point out that the DRG system covers reimbursement for the direct expenses associated with inpatients only. Indirect expenses and expenses for outpatient services are covered by the principles of the 1978 law which created the state rate-setting commission. This law requires that the financial solvency of all New Jersey hospitals be maintained, applies to all payors and provides for reasonable operating expenses, equipment and facility replacement costs, bad debts and charity allowances, and working capital requirements. These features are clearly more positive than those financial requirements reimbursed under the SHARE system.

3. "Do you believe that many of the negative aspects noted in your statement can be attributed to initial program startup?"

A year ago I might have said that the delay in issuing rates, mid-year changes in these rates, and the delay in settling appeals in year-end reconciliation were a part of the initial startup problem. I no longer feel that these problems are part of the normal difficulties of beginning a new complicated system.

There has been considerable turnover in personnel in the Department of Health. This department provides the staff support for the rate-setting commission. Very few, if any, of the principal people who initiated the program remain. Personnel who have replaced them are not as familiar with the system. Vacancies exist and the department is concerned that the general state budget reductions will affect necessary positions. Computer support systems and personnel also are inadequate and contribute to delays. In my opinion, the backlog of decisions, which has developed since the system began in 1980, is so extensive that the likelihood of the system becoming prospective in the near future is very remote.

I hope that this additional information will be useful to the subcommittee in its work.

Sincerely,

Donald W. Davis
President
Hunterdon Medical Center
Flemington, N.J. 08822

Senator DURENBERGER. Let's go to Rhode Island. With whom shall we start? Mr. Murray?

Mr. MURRAY. I was hoping he would defer to me.

Senator DURENBERGER. I always do, John.

STATEMENT OF JOHN C. MURRAY, ASSISTANT DIRECTOR OF ADMINISTRATION FOR PLANNING AND FINANCIAL MANAGEMENT, STATE OF RHODE ISLAND, PROVIDENCE, R.I.

Mr. MURRAY. Mr. Chairman, I am John Murray, assistant director of administration for planning and financial management, State of Rhode Island. I have spent most of my career as the budget officer for the State of Rhode Island before moving up to this level. The critical point involved in there is that my career has been in public budgeting and in financing.

I have associated with me today, simply accompanying me, Mr. Armand Leco, who is senior vice president of Blue Cross and Blue Shield of Rhode Island. I think just the fact that he is sitting beside me is an indication that what we are doing in Rhode Island is quite different from what is happening in the other States that you are hearing today.

We do not have a ratesetting commission in the State of Rhode Island, statutorily based. This does not mean to say that rates do not come out of the product of our efforts. What we are doing is, however, statutorily mandated. The genesis of the system of prospective reimbursement in the State of Rhode Island goes back to 1969. And there are three people at this table who have participated in that for 13 years. I might also say that Mr. Davis was a participant for some 4 or 5 years, I would guess, when he was in the State of Rhode Island. In fact, I might also point out that of nine witnesses today four of them have professional experience in the State of Rhode Island; so, as small as we are, I think there is a voice that you are hearing today.

So the genesis went back to 1969 when the Department of Business Regulation of Rhode Island, which covers insurance companies, the director of such department was distraught by the repeated appearance year after year of Blue Cross or Rhode Island seeking what were believed to be fantastic insurance premium increases, so distraught that he directed Blue Cross to go and find a different way of reimbursing hospitals rather than on a retrospective cost basis.

Blue Cross did not set about to fly out fiats and mandates to the hospitals; instead it commenced a movement in the direction of clearly relaying it to hospitals on what the problem was to be solved.

In 1971, the State of Rhode Island passed legislation which stipulated—and this is our statutory base—that the State of Rhode Island, acting through the budget officer or his designee, and that's how I got into this, the hospitals and hospital service corporations, of which there is only one, Blue Cross of Rhode Island, shall be parties to budget negotiations held for the purpose of determining rates of payment for hospital costs by the State and such corporations.

We were directed to do this—of course there were no other provisions in my statement that I submitted, which I hope will be reproduced in the record, in the support of part of that. There were no stipulations as to how we were to proceed to do this thing.

So we convened the parties and actually evolved there from a body of agreed-upon elements in a protocol document. This has been amended over the course of time, as one would expect, but this is how we are guided in what we are doing.

Now, what do we do? We're small, and we can do something, but it does not mean that what we are doing can't be transferred to a larger geographical area. We set, on a budgetary basis, a cap on the increment in cost for the next year for the entire hospital system of Rhode Island. This is a statewide, what we call a maxicap.

Having established the magnitudes to be spent in the system, and the cap includes a reserve for contingencies and for some settlings that we must do at the close of each year because we have corridors relating to numbers of patient days, ancillary service, and such, in the setting of the maxicap I think we bring to it some pretty sophisticated information and documentation from both sides.

Blue Cross works very closely of course, as you would expect in this, with the State budget office; and the hospital, of course, does not operate individually in setting their maxicap, they operate as an association.

The State budget office has an econometric model for the State of Rhode Island which was developed in conjunction with Data Resource, Inc., DRI—Arlo Aexnine's organization. And our model, which is constantly updated by us, of course, is driven by the macromodel.

We also have as a subscriber to that relationship with DRI, which incidentally costs us something like $60,000 to $70,000 a year, we then are able to have available to us its special publications and research, the publication being Health Care Costs, only for subscribers. This zeros in on marketbasket items for hospitals. All the data that we think is needed and can be most professionally obtained is available to us.

We bring into these proceedings and we negotiate over what the estimates are going to be of costs for the coming year. We do ultimately agree on the maxicap.

Subsequently, we negotiate for the individual hospital rates. There are only 16; but, nevertheless, it turns out to be the case that all hospitals don't get the cap—they may get less or more depending upon the requirements of the individual hospital, the requirements of statewide need to be met by hospitals in a certain area rather than in other areas. When we have a 12-percent or a 10-percent cap, hospitals can get 17 or 18 percent—individual hospitals. Others will receive only 8 or 9 percent. And this is how the system does work out.

Mr. Dietz is a strong participant in this process and I'm sure will go over some of these things; but, having heard some of the findings and suggestions as to outcomes in other jurisdictions, I would like to quickly go to what has happened with us.

In 8 years of setting caps—the first year we set the highest cap. Of course we didn't know it was the highest cap we were about to set. But in fiscal 1975 we set a cap of 13.85 percent above the prior year. In the following year we dropped it to—and when I say "we," it doesn't mean myself or this man; it means the group, the negotiants—we dropped it to 11.5 percent. We had 4 successive years when it was less than 11 percent on an annual basis. In 1981 it moved to 11.98, and in this past year to 12.99.

Now, how does this compare to what has been happening over the Nation? This is all in your documentation, Mr. Chairman.

I would point out that the Rhode Island average as compared to the U.S. average in operating expense growth in our first year, 1975, was only 7 percent less than the national growth. I say "only" because the following year it was 40 percent less; followed by such years, 27, 36, 20, and 26 percent.

If I were to look at this another way—always dealing in budgets and with the people I have to sell budgets to—I would turn it around the other way and say that if Rhode Island's rates were to go up to the national rate, rather than being looked at as a reduction of such, the rate increases would have been 8 percent, 64 percent, 40, 44, 25, and 30.

I might also say—I asked Mr. Schramm, but I'm sure he forgot about it—that when this remarkable article came out in the New England Journal of Medicine, and he had six States involved, rate-setting States, one, we were happy to see that Connecticut was in there. We knew their rate setting, but what we also knew was that the executive director of the Rate-Setting Commission in Massachusetts used to be my chief negotiator, and I think he learned substantially what he was doing in the State of Rhode Island system, which was evolving.

I asked the people who performed this study now to look at what the State of Rhode Island was doing and to run our numbers through the same system which evolved from this. He forgot to mention that we compared favorably, maybe better, throughout all of this. One of Mr. Schramm's associates has indicated to me today that they are still running Rhode Island's numbers through, and we are still holding our position in outcome of equivalent character.

I will close at this point. I won't take all of my time, because Mr. Dietz, I'm sure, will say some of the things that I am saying, probably in a different way.

But I think you should have noticed what Mr. Derzon said. When you move into—first of all, the States that got into prospective reimbursement in the first instance were high-cost States; and I'm sure that's true, because we here in the State of Rhode Island—"If you're doing so well, how come the rates are so high?" They are so high because they were so high when we started, and the practice of medicine in the east coast and the Northeast is different from the rest of the Nation.

He also pointed out that successes will be very substantial in the first few years, and then they will gradually decline. And as you will see, my numbers did decline.

And I would agree with something that you were suggesting, Mr. Chairman. You said prospective reimbursement tends, it would

seem, to put hospitals in sort of a capital-poor position. Well, you know, all budgeting does that, whether it is at the national level, the State level, or the local level. It puts all of those entities, including hospitals—this is good budgeting, strong budgeting—it puts them in cash-difficult situations. I don't know how to solve that. It's easier to solve with hospitals in the private sector, however, than in the public sector.

Thank you, Mr. Chairman.

Senator DURENBERGER. Thank you.

[The prepared statement of John C. Murray and answers to questions from Senator Durenberger follow:]

Rhode Island Prospective Reimbursement of Hospital Costs
Summary of the Principal Points

1. Prospective Reimbursement Program began in 1971, interrupted in 1973 due to Phase III of the Economic Stabilization Program, reinstituted in 1975 and continues to the present.

2. Prospective Reimbursement Program has its basis in State Law.

3. Participants in the program include the State Budget Office, the sixteen voluntary hospitals in the state and Blue Cross of Rhode Island.

4. Basic elements of the program are:

   a. negotiation of a statewide Maxicap on expenses
   b. negotiation of individual hospital operating budgets
   c. determination of Third Party payment rates
   d. adjustment of payment rates at fiscal year end to reflect volume.

5. Program Effectiveness

   a. Period 1970-1979 - Rhode Island's average annual increases in hospital expenses (10.9%) was second lowest in the nation.

   b. Same period, 1970-1979 - Rhode Island ranked third lowest (11.2%) in average percentage increase in hospital expenditures per case, and fourth lowest (11.1%) in hospital expenditures per capita.

RHODE ISLAND: - PROSPECTIVE REIMBURSEMENT OF HOSPITAL COSTS

Materials Presented by Rhode Island Department of Administration

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Overview of Prospective Reimbursement Program in Rhode Island

The Rhode Island Prospective Reimbursement Program was initiated in response to the concern of the Rhode Island Department of Business Regulation. In 1969, the Director of the Department expressed strong concern over the magnitude of insurance premium increases and he directed that a new manner of hospital reimbursement be developed to control hospital costs. Up to that point, hospitals were paid their actual costs after service had been rendered to a patient, an arrangement termed retrospective cost reimbursement.

The Prospective Reimbursement Program actually began in 1971 when the hospitals guaranteed their operating expense budgets; the negotiation of these budgets was initiated in 1972. The program was interrupted in 1973 due to Phase III of the Economic Stabilization Program, but was reinstituted in 1975 and continues to the present.

The key element of the program is that hospitals are reimbursed not on actual costs but on the basis of prospectively determined costs which result from prospectively negotiated operating expense budgets. In essence, a hospital agrees in advance to its operating expenses for the coming fiscal year, and these expenses are the basis for Third Party reimbursement.

Program Overview

The Prospective Reimbursement Program has its basis in State law. In 1971, amendments were added to the enabling act for nonprofit hospital service corporations which mandated that hospital budget negotiations be held for the purpose of determining payment rates for hospital costs.

The current participants in the program are the State Budget Office, the sixteen voluntary hospitals in the State, and Blue Cross of Rhode Island. For fiscal years 1975 through 1977, the Social Security Administration (Medicare) also participated due to the designation of the Rhode Island Program as a three year experimental cost containment program, but no longer participates due to the fact that the Program is no longer experimental. Medicare still benefits from the Program's existence because overall hospital expenses are being kept in check.

The objectives of the Program reflect its comprehensive nature. These are to:

A. Contain costs,

B. Assure that growth in programs is based upon statewide needs,

C. Shift health resources from inpatient care modalities,

D. Reward management efficiencies and improve productivity, and

E. Ensure that cost control efforts do not have a deleterious effect on patient care.

Generally, we feel that it is possible to contain costs while allowing for new program growth and ensuring quality of care.

The program is composed of the following basic elements:

A. The negotiation of a statewide MAXICAP on expenses.

B. The negotiation of individual hospital operating budgets.

C. The determination of Third Party payment rates.

D. The adjustment of Third Party payment at fiscal year end to reflect volume.

Additionally, there are mechanisms to adjust hospital budgets for unforeseen circumstances, termed major contingencies and to adjust budgets for the intensity of patient cases. If the negotiation process fails to reach agreement on MAXICAP or individual budgets, resolution is achieved through mediation and, if necessary, arbitration. Each component of the process deserves some additional explanation.

Statewide MAXICAP

The Statewide MAXICAP represents a "negotiated outside guarantee on the aggregate operating expenses of all the voluntary hospitals within which all hospital budgets must be negotiated and a reserve maintained for unforeseen expenses during the fiscal year." This is perhaps the most significant program element, particularly from a cost containment perspective.

In the development of their respective positions for the initiation of MAXICAP negotiations, the hospitals and Third Parties utilize a wide variety of economic indicators. These include (among other factors) national and regional inflation projections, local and national labor contract experience and unique local circumstances. The State Budget Office's econometric model for Rhode Island which is driven by Data Resources, Inc. (DRI) macro-model is of particular value. So also is the flow of specialized data available to the Budget Office from DRI's publication "Health Care Costs."

The negotiating process centers on the following MAXICAP components: salaries and wages, supplies and other expenses, depreciation, interest, new programs, volume, plus a "reserve" factor to protect against volume/intensity fluctuations and major contingencies (unforeseen expenses).

The final MAXICAP is the aggregate of the projected increases of all these factors.

A major element in the determination of the MAXICAP which deserves more explanation is the factor allowed for new programs. There are two major sources of input to this factor: (1) the certificate of need program and (2) the voluntary medical program review process.

The Rhode Island Certificate of Need (CON) program reviews capital and major medical equiment proposals which have associated capital costs which exceed $150,000. The 1979 CON program also began reviews of new medical programs meeting a $75,000 operating expense review threshold. The State Budget Office, the hospitals and Blue Cross are all represented on the Council which reviews CON proposals.

A unique element in Rhode Island is the presence of a voluntary medical program review process. Initiated in 1972, the process reviews new and expanded hospital medical programs which have associated operating expenses exceeding review thresholds. These thresholds are graded according to the individual hospital's overall operating expense budget.

The result of the medical program review is that programs are assigned priorities. A Priority I program's implementation is encouraged, and the associated costs are included in the MAXICAP component for new programs. Priority II programs are those which require more planning before they are recommended for implementation. A program receiving Priority III designation is not funded at all.

The results of both planning processes--CON and the voluntary program--are utilized in MAXICAP negotiations.

Hospital Budget Negotiations

Subsequent to agreement on a MAXICAP, individual hospital budgets are negotiated. This process proceeds along the following steps:

1. Budget submission to the Third Parties,
2. Budget review and analysis, and
3. Negotiation of operating expenses and utilization statistics (e.g., patient days, ancillary services).

Recalling that the MAXICAP is applied to aggregate expenses of all voluntary hospitals, individual hospital budgets may increase by various percentages both above and below the MAXICAP. Thus, the program can respond flexibly to individual hospital financial needs which may vary considerably from one year to the next--at the same time that costs are contained in total.

Third Party payment is established based on the results of budget negotiations coupled with each Third Parties' principles of reimbursement.

Volume Corridors

The Program includes volume corridor provisions which essentially allow and correct for shifts in patient care volume. More importantly, the corridors provide incentives to shift volume from the inpatient to the outpatient modality. This is accomplished through the application of differential reimbursement rates for inpatient versus outpatient utilization.

Major Contingency

As previously mentioned, the program includes a "major contingency" provision to protect all parties against unforeseen and unexpected events which impact hospital expenses. For example, several years ago unusual increases in malpractice expenses resulted in a major contingency. Once negotiated, major contingency expenses constitute legitimate adjustments to the MAXICAP and individual hospital budgets.

Mediation and Arbitration

The heart of the program is negotiations which are often marked by strong disagreements and conflicts. Of necessity, the program contains an appeals process to resolve disputes: mediation and arbitration. Issues which have gone to mediation include individual hospital budget disputes, major contingency allowances and MAXICAP resolution among others. If an issue is not resolved by mediation, the process turns to arbitration. In summary, the appeals process provides a mechanism that assures resolution short of legal recourse.

Program Effectiveness

We feel that the program has been unequivocal in its success. For the ten year period from 1970 - 1979, Rhode Island's average annual increase in hospital expenses (10.9%) was the second lowest in the nation. For the same period, Rhode Island ranked third lowest (11.2%) in average percentage increase in hospital expenditures per case and fourth lowest (11.1%) in hospital expenditures per capita (see page 18).

Undoubtedly, the key point to be made in regard to the Rhode Island experience is that the cost containment results have been achieved by a non-regulatory program which allows for the maximum possible degree of flexibility for hospital management. This has been accomplished through the cooperative efforts of hospitals and Third Parties, working to maintain the quality and comprehensiveness of health services in Rhode Island.

BASIC ELEMENTS OF THE RHODE ISLAND PROSPECTIVE REIMBURSEMENT PROGRAM

State of Rhode Island and Providence Plantations

Department of Administration

Division of the Budget

State House

Providence, Rhode Island 02903

February 1982

Basic Elements of the Rhode Island Prospective Reimbursement Program

Purpose

The purpose of the prospective reimbursement program is to demonstrate that a statewide program of prospective rate setting with incentives based on budget negotiations within a statewide limit on total allowable cost increases has substantial power to:

1) Contain cost
2) Assure that growth in programs is based on statewide need
3) Shift some proportion of health dollar investments from in-patient to other patient care modalities
4) Reward management efficiencies and improved productivity
5) Ensure that cost control efforts do not have a deleterious effect on patient care

Authorization

A waiver of Medicare/Medicaid principles for retrospective reimbursement is in effect per Section 232 of P.L. 92-603 for the State Medicaid program. Blue Cross participates in this program through an amendment to its basic contract with the hospitals.

Duration of Program

The "experimental" portion of the program ran from October 1, 1974 to September 30, 1977. This was funded in part by the Office of Research and Statistics, Social Security Administration. During this period Medicare was a participant in this reimbursement program. When the experimental status of the program ended on September 30, 1977, the parties to the process agreed to extend the program, pending potential legislative action at the federal level.

Participants

-State of Rhode Island - Division of Budget/Medicaid
-Blue Cross of Rhode Island
-Hospital Association of Rhode Island - 16 voluntary hospitals, consisting of 14 short-term, acute care hospitals for an aggregate of 3,590 beds; and 2 psychiatric hospitals.

Administration

A protocol stipulating the intent and rate-setting procedures of the prospective rating program provides overall guidance.

There is one chief negotiator each from Blue Cross and from State/Medicaid who negotiate opposite a negotiating committee made up of hospital administrators and hospital association personnel.

Major Features

I. Maxicap

The Maxicap is an overall ceiling or maximum on hospital expenses for all 16 voluntary hospitals participating in the program. This Maxicap is negotiated by all parties prospectively.

Thus far there have been eight Maxicap negotiations. Results have been:

FY 1974-75:	Actual 1973-74 expenses x 113.85% = total available dollars to hospitals.
FY 1975-76:	Total FY 1974-75 available dollars as established above and adjusted for any major contingencies and volume corridors x 11.5% = total available dollars to hospitals.
FY 1976-77:	Total FY 1975-76 available dollars x 110.50%.
FY 1977-78:	Total FY 1976-77 available dollars x 110.42%.
FY 1978-79:	Total FY 1977-78 available dollars x 110.27%.
FY 1979-80:	Total FY 1978-79 available dollars x 110.50%.
FY 1980-81:	Total FY 1979-80 available dollars x 111.98%.
FY 1981-82:	Total FY 1980-81 available dollars x 112.99%.

A. Reserve:

Each year, a portion of the Maxicap is set aside, i.e. not allocated to individual hospital budgets, in order to absorb any contingency or excess volume expenses that may develop. Before the reserve is used for such expenses, all parties must negotiate and agree on the legitimacy and amount of these expenses.

B. Major Contingency Clause:

This provision allows a hospital or hospitals to be reimbursed for a major, unforeseeable, uncontrollable expense not originally considered when prospective budgets and rates were set. Malpractice insurance premium increases are an example.

C. Volume Corridor:

There are corridors to determine the amount of revenue retained and added to an expense budget when increases in volume in excess of budgeted levels occur. These corridors include assumptions of variable costs in hospital expenses for inpatient routine care, inpatient ancillaries and outpatient services. (See next page)

Volume Corridors

Routine Care

Patient Days Increase	Percentage of Per Diem Payable
0 - 5%	20%
5 - 7%	30%
7 - 10%	40%
> 10%	Renegotiate

Patient Days Decrease	Percentage of Per Diem Payable
0 - 5%	80%
5 - 7%	70%
7 - 10%	60%
> 10%	Renegotiate

Inpatient Ancillary Revenue

Increased Volume:

(Actual Revenue) - (Budgeted Revenue x 1.01) = Excess Revenue x 0.35 = amount retained and added to negotiated expense base.

Decreased Volume:

(Budgeted Revenue - Actual Revenue) x 0.65 = amount due hospital from third parties. If 10% decrease in admissions occur, the amount of adjustment must be negotiated. Stipulations governing protection for decreased volume: length of stay increases when admissions decrease will trigger a reduction in the amount of protection generated by the 65% factor.

Outpatient Revenue

(Actual Revenue - Budgeted Revenue) x 0.60 = amount of revenue retained and added to expense base.

II. Individual Budget Negotiations

Each hospital's expense budget undergoes prospective review and analysis by a team of Blue Cross/State Budget Office analysts. Then the hospital administrators and the team of third party negotiators sit down and negotiate with each other to settle the budget at a level that reflects a compromise between each side's position on the level of resources necessary for a hospital to operate on during the upcoming year.

Although the analysis necessary to develop a negotiating position for the third parties is as detailed as possible, after initial negotiation sessions bottom-line negotiations take place. The principle of an individual hospital's right to maintain its management prerogatives is guarded well by the hospitals and is reflected in bottom-line negotiations. However, items such as new programs, statistical projections on volume, and lengths of stay are often agreed on specifically by all parties.

A. Cost-Finding and Setting of Rates

Following completion of budget negotiations, each budget goes through cost-finding to make sure that expense allocations to cost centers and the relevant revenue projections are consistent with the dollars and statistics negotiated. Hospital cost allocations are also reviewed against past years' data to see if any unusual changes in accounting or operations have occurred to alter reimbursement.

Each major third party establishes its respective ratio of costs to charges (RCC) according to its principles of reimbursement. These RCC's form the prospective rates for inpatient and outpatient services during the coming year. No interim rates are paid. Year-end adjustments are not reconciliations of the prospective RCC to actual reimbursement but reflect the operation of agreed-upon volume corridors as discussed previously in this outline.

B. Monitoring System

A fledgling computerized data system has been established to obtain a month-by-month cumulative record of each hospital's volume and associated expenses and is necessary to monitor each hospital's progress relative to the expenses and statistics negotiated prospectively.

III. Medical Program Review Process

A medical program review process is in place which requires all hospitals to submit proposed new or expanded medical (non-capital) programs which exceed predetermined dollar criteria to an independent voluntary review body for evaluation prior to budget negotiations. This process identifies and ranks programs having a demonstrable community need in the budget year. Other programs of merit which are not considered essential for implementation in the budget year are given a lower priority ranking. Final decisions on whether a program becomes incorporated into a hospital budget are retained in the negotiation process. If a program is approved, it becomes part of the hospitals' final approved budget and thus subject to the statewide MAXICAP limitation.

IV. Utilization Review

Realizing that professional standards review organizations (PSRO) were not slated to be in full swing until halfway through the program, the third parties negotiated with the hospitals an agreement to implement an independent utilization review process that would be fully controlled by PSRO when PSRO became operational.

In 1981 with the phasing out of PSRO, the utilization review activities have been assumed by the state Medicaid program.

V. Qualified Hospital Cost Containment Program

In 1982, the Rhode Island prospective reimbursement program was designated as a qualified hospital cost containment program. Rhode Island is one of only seven states which has received this designation.

VI. Mandatory Program vs. Voluntary Program

The Rhode Island program has characteristics of both a mandatory program and a voluntary program. By state law, hospitals are required to negotiate rates of payment with the state and Blue Cross. By a voluntary contract, the parties have agreed as to how the actual process will be carried out.

R2/77-5

Chapter 19
NON-PROFIT HOSPITAL SERVICE CORPORATIONS
General Laws of Rhode Island

AN ACT Providing for Negotiation of Hospital Cost.

It is enacted by the General Assembly as follows:

Section 1. Chapter 19 in title 27 of the general laws, as amended, entitled "Non-profit hospital service corporations," is hereby further amended by adding thereto the following sections:

"27-19-14. **NEGOTIATION OF HOSPITAL COST.** -- The state, acting through the budget officer or his designated representative, hospitals and hospital service corporations incorporated under chapter 27-19 of the general laws shall be parties to budget negotiations held for the purpose of determining payment rates for hospital costs by the state and such corporations. Such negotiations shall be held for all hospital fiscal years beginning on and after October 1, 1972 and such negotiations shall commence not later than ninety (90) days prior to the beginning of each hospital fiscal year. The parties may employ mediation and conciliation services as an aid to such negotiations.

"27-19-15. **AGREEMENT ON BUDGETS.** -- The budgets and related statistics shall be agreed upon not later than thirty (30) days prior to the beginning of each fiscal year. Such agreement shall be prima facie evidence that the budgets and related statistics are (1) consistent with the proper conduct of the business of said corporations and the interest of the public to the extent that such budgets constitute in the aggregate a component of hospital service rates filed for approval in any rate hearing, and (2) reasonable as a component of rates paid by the state as a purchaser of hospital services.

"27-19-16. **SEVERABILITY.** -- If a court of competent jurisdiction shall adjudge that the requirement in section 27-19-14 that the state be a party to negotiations in which the United States is a party or otherwise interested is invalid or unconstitutional, such judgment shall not impair or invalidate that section insofar as it requires the state to be a party to negotiations between hospitals and hospital service corporations; and if any other clause, sentence, or section of sections 27-19-14, 27-19-15, 27-19-16 is adjudged invalid or unconstitutional by a court of competent jurisdiction, the remaining provisions of said sections will not thereby be impaired or invalidated, but the effect of such judgment shall be confined to the clause, sentence, or section so adjudged to be invalid or unconstitutional. If the United States or any of its departments or agencies requires that funds supplied by it to the state for the purchase or reimbursement of hospital services be disbursed in a manner inconsistent with any agreement reached by the parties pursuant to sections 27-19-14 and 27-19-15, such requirement shall not affect any such agreement as to other funds to be paid by the state or by hospital service corporations.

Sec. 2. This act shall be effective upon passage.

JCM/dk/2/99

Excerpt from
State of Rhode Island
DIGEST OF ANNUAL REPORTS
1980-1981

- **Prospective Budgeting for Hospitals:** The prospective rating program initiated on October 1, 1974, as an effort to contain hospital cost increases, will start its eighth year of operation during the fall of 1981. Started as a three-year experimental program with participation from Blue Cross of Rhode Island, the Hospital Association of Rhode Island, the State Division of the Budget, and the Social Security Administration (Federal Medicare), the program has been continued beyond this experimental period by the three local parties. Since October of 1977, Medicare reimbursement has reverted to the cost reimbursement process that existed prior to prospective reimbursement, while Blue Cross and state reimbursement continue to be based on the prospective budgets with the accrual of significant cost savings to the third party payors.

The historical record for total hospital expense growth has been as follows:

Experience of Rhode Island Under
Prospective Reimbursement Program in Effect Since 1975

NET REVENUE GROWTH

U.S. Average*	Rhode Island Average	Years
19.5%	17.1%	1975
17.8%	11.4%	1976
17.5%	11.8%	1977
13.5%	11.4%	1978
17.3%	14.2%	1979
18.4%	13.2%	1980

GROSS OPERATING EXPENSE GROWTH

U.S. Average*	Rhode Island Average	Years
17.5%	16.2%	1975
19.1%	11.6%	1976
15.6%	11.1%	1977
12.8%	8.9%	1978
15.1%	12.0%	1979
17.0%	12.8%	1980

*U.S. data based on American Hospital Association (AHA) Annual Statistics, except 1977 data which is based on AHA panel surveys for three quarters in 1977.

JCM/dk/2/100

U. S. COMMUNITY HOSPITALS
ANNUALIZED PERCENTAGE INCREASE:
EXPENSES PER ADJUSTED DAY, PER CAPITA, AND PER ADJUSTED ADMISSION
1976 - 1979

State	Statutory Rate Setting	Col. 1 Annualized Percentage Increase Expenses/ Adj. Day	Col. 2 Annualized Percentage Increase Cost/ Capita	Col. 3 Annualized Percentage Increase Expenses/ Adj. Admis.	Col. 4 Rank (Col.3)
Vermont		9.6	7.2	7.4	1
New York	Mandatory	8.9	8.5	8.0	2
Rhode Island	Mandatory	9.7	10.7	8.8	3
Connecticut	Mandatory	10.0	10.5	9.6	4
Massachusetts	Mandatory	9.3	10.2	9.8	5
Maryland	Mandatory	10.8	12.7	10.1	6
New Jersey	Mandatory	10.3	11.2	10.2	7
Delaware		10.9	12.0	10.6	8
Kentucky		13.0	13.1	10.9	9
Florida		11.6	14.0	11.5	10
Tennessee		13.1	15.8	11.5	11
Washington	Mandatory	11.0	10.0	11.5	12
Georgia		11.6	14.0	11.7	13
Arizona		12.6	12.8	11.8	14
Illinois		13.7	13.8	11.8	15
Indiana		13.4	13.8	11.9	16
Michigan		12.8	27.7	11.9	17
Wisconsin	Mandatory	13.2	11.5	11.9	18
South Carolina		12.9	13.3	12.1	19
Oregon		13.9	12.1	12.1	20
Nebraska		12.6	12.4	12.4	21
Ohio		13.9	13.1	12.5	22
Mississippi		12.8	17.3	12.5	23
West Virginia		13.6	12.9	12.6	24
New Mexico		13.5	13.1	12.8	25
Texas		13.5	13.6	12.9	26
Pennsylvania		13.7	14.2	13.0	27
Minnesota		11.4	11.0	13.0	28
North Dakota		11.4	12.9	13.0	29
Virginia		12.9	13.9	13.1	30
Alabama		13.9	17.7	13.2	31
North Carolina		13.8	14.0	13.2	32
South Dakota		16.1	12.9	13.3	33
New Hampshire		13.5	12.1	13.3	34
Wyoming		18.7	10.8	13.5	35
Iowa		14.9	13.7	13.6	36
Oklahoma		13.3	15.3	13.6	37
Colorado		13.3	11.3	13.6	38
Missouri		13.8	14.6	13.7	39
Arkansas		13.6	15.2	13.7	40
Louisiana		14.7	16.6	13.9	41
Utah		16.2	14.2	13.9	42
Maine		12.2	14.5	14.0	43
California		14.2	12.8	14.2	44
Idaho		13.5	12.1	14.3	45
Nevada		16.1	15.5	14.3	46
Kansas		15.6	15.8	15.0	47
Hawaii		11.6	15.6	15.4	48
Montana		7.9	13.9	16.4	49
Dist. of Columbia		15.9	15.3	18.3	50
Alaska		19.4	24.8	24.3	51
U. S. AVERAGE		12.4	12.6	11.8	

Source: Hospital Statistics, Data from the American Hospital Association Annual Survey (1976-1979 Editions). Table is a collection of HCFA material.

Ranked according to Annualized Percentage Increase/Adjusted Admission.

R2/233

U.S. Community Hospitals
Hospital Expenditures Percentage Change:
Per Capita, Per Case, and Annual Expenditures, 1970-1979

State	(Col 1) 1970-79 Hospital Expenditures Per Capita Annual Percentage Change	(Col 2) 1970-79 Hospital Expenditures Per Case Annual Percentage Change	(Col 3) 1970-1979 Hospital Expenditures Annual Percentage Change	(Col 4) Rank (Col 3)
Vermont	9.3	10.1	10.6	1
Rhode Island	11.1	11.2	10.9	2
New York	11.9	10.6	11.5	3
Minnesota	10.8	11.9	11.6	4
Dist. of Columbia	13.2	13.7	12.2	5
Connecticut	12.2	11.4	12.5	6
Massachusetts	12.4	12.3	12.6	7
South Dakota	12.3	11.6	12.7	8
Hawaii	10.6	11.2	12.8	9
Montana	11.7	13.0	13.3	10
Wisconsin	12.5	12.9	13.4	11
Washington	12.0	12.6	13.7	12
North Dakota	13.0	13.0	13.8	13
Delaware	13.0	12.4	13.8	14
Nebraska	13.0	12.1	13.8	15
Iowa	13.7	12.3	14.1	16
New Jersey	13.9	11.7	14.1	17
New Hampshire	11.9	12.1	14.2	18
Pennsylvania	14.4	12.5	14.3	19
U.S. Average	13.5	12.2	14.5	
West Virginia	13.7	12.4	14.6	20
Ohio	14.5	12.1	14.6	21
Kentucky	13.9	11.8	14.6	22
Wyoming	10.9	13.7	14.7	23
Illinois	14.6	12.6	14.7	24
Indiana	14.2	12.4	14.7	25
Idaho	11.8	12.6	14.8	26
California	13.3	13.7	14.9	27
Oregon	12.5	13.5	14.9	28
North Carolina	13.7	12.3	14.9	29
Utah	11.7	11.8	14.9	30
Kansas	14.3	12.6	15.0	31
Maryland	14.3	11.9	15.0	32
Colorado	12.2	13.3	15.1	33
Missouri	14.8	12.4	15.3	34
Michigan	15.0	12.7	15.4	35
Virginia	14.3	15.4	15.7	36
Texas	13.4	12.1	15.7	37
South Carolina	14.2	12.6	15.8	38
Arkansas	14.2	14.5	15.8	39
Mississippi	14.8	12.0	15.9	40
Oklahoma	14.6	13.1	16.1	41
Tennessee	14.7	11.9	16.1	42
Alabama	15.2	12.4	16.3	43
Maine	15.4	14.3	16.7	44
Georgia	15.4	13.1	16.8	45
New Mexico	14.3	14.1	16.9	46
Arizona	13.0	12.6	17.2	47
Florida	14.8	12.4	18.2	48
Louisiana	15.0	13.4	19.3	49
Nevada	15.0	14.1	19.7	50
Alaska	20.2	18.1	24.2	51

Source: Background Data on Changes in Hospital Expenditures and Revenues 1970-1979 prepared by IFC Incorporated, submitted to Federation of American Hospitals

N2/197

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Administration
DIVISION OF THE BUDGET
State House
Providence, R. I. 02903

August 5, 1982

Mr. Robert E. Lighthizer
Chief Counsel Committee on Finance
Room 2227, Dirksen Senate Office Building
Washington, D. C. 20510

Dear Mr. Lighthizer:

Attached are responses to the questions by the committee in regards to the hearing held on the State hospital payment system held on June 23, 1982. I hope these responses answer the questions of the committee.

Sincerely,

John C. Murray
COORF

John C. Murray
Assistant Director: Planning &
Financial Management

JCM:sm/R2/296

Attachment

cc: Sen. David Durenburger

Questions for Mr. Murray:

1) How frequently have you had to use mediation or arbitration to reach agreement on MAXICAP or individual budgets?

2) Does your program take into account differences in types or locations of hospitals -- such as teaching/nonteaching or urban/rural?

3) In that your program does not cover all payors -- Medicare has not been included since 1978 -- have you seen any evidence of cost shifting to patients not covered by your program?

4) Why is Medicare no longer covered by your program?

ANSWERS TO QUESTIONS FROM SUBCOMMITTEE ON HEALTH

1. The mediation process has been utilized five times to settle budgets, while arbitration was utilized in two (2) additional cases to settle hospital budgets. The Maxicap has been settled using mediation only once.

   Arbitration was utilized by the State to settle an issue involving malpractice with all the hospitals.

   Currently, the issue of application of audit adjustments retrospectively is in arbitration. In addition to the current third parties (State and Blue Cross), Medicare is also party to the arbitration.

2. Each individual hospital's needs are reviewed and studied by the third parties in the negotiating process.

3. Cost shifting is taking place but it is felt that the prospective program is not the prime reason in the shift; rather, much of the shift is due to new regulations that are being formulated by HCFA.

4. Medicare is no longer in the program because the prospective system in Rhode Island is not formularized enough for Title XVIII. Further, Medicare is getting the benefit of reduced costs without having to provide waivers from any of its more restrictive provisions.

Senator DURENBERGER. Mr. Dietz?

STATEMENT OF MR. FRANCIS R. DIETZ, PRESIDENT, MEMORIAL HOSPITAL, PAWTUCKET, R.I.

Mr. DIETZ. Thank you, Senator. I appreciate the opportunity to share my views today with you.

I will make my address from two viewpoints: One, as John said, as an active participant in the Rhode Island system, and also as an administrator of a local hospital.

I was extremely pleased during your opening comments that you did make one statement that I believe very strongly about, and that is the concern of what is going to happen to quality in setting prospective rates. I believe that any system design that addresses just the cost side of the ledger and ignores quality is not going to be in the best interests of the citizenship that we serve.

As John said, we are not novices to prospective rates. We have been in the business of doing it collectively in the State of Rhode Island for about 12 years and have a track record that I think stands for itself.

But in terms of quality, I can also say to you that the hospitals in the State of Rhode Island do feel that the necessary programs and services to meet the needs of our patients have also been achieved during a setting that reduced hospital costs.

In our State, during the same identical period, 1969 to the present date, that we have had prospective rates, that we have kept our costs below the national average, we have built an entire medical school. I think we all appreciate and understand the large expenditure that a medical school brings to the system, but that system was built in the State of Rhode Island while we kept costs down.

So I would strongly suggest that quality can be achieved in a system of prospective rates and in no way necessitates the feeling that it will suffer, if properly administered.

The second thing I would like to stress is what John said. It is that in Rhode Island we don't have a mandated ratesetting commission; we truly have a cooperative venture composed of—quite appropriately in the State of Rhode Island—the member hospitals, the State budget office, and Blue Cross/Blue Shield of Rhode Island which is a major purchaser of health care on behalf of the citizenship.

Our approach deals with bringing the bodies together and placing squarely on their shoulders the syndrome of cost-versus-quality, and we solely and equally share any outcome of that. We stand collectively accountable to our citizenship as to what the price is going to be and what the quality is going to be; and by all of us participating, none of us can run away from it or blame one another.

I think one of the concerns I have about mandated ratesetting is that I think it can polarize the parties, namely, the hospitals versus the regulators, into one blaming one side for the exhorbitant costs and the other blaming the other side for a diminishing of quality.

I think a system that can encourage the parties—and we all should be equally concerned. As a hospital administrator I am as

concerned about the cost of health care to my community as anyone else is. I have a responsibility to that community not only to deliver care but I have a responsibility to do it at the best possible price.

I think, in our State, the State government has exhibited the concern on the other side as Blue Cross has, that they are concerned about the quality and the proper services and not just about the price.

So I would encourage you, as you explore anything, to find a way as we have in Rhode Island to get us to cooperatively go together.

That doesn't mean that everything is just peaches and cream. John said that we have a system and at the heart of everything we do is negotiations. And I can truly tell you as a participant both in designing the system, in negotiating annually maxi-caps, and in negotiating my own hospital's budget, that those sessions are true, hard negotiations.

As John says, he attempts to get facts, and with Blue Cross, about inflation components. We, as hospitals, do the same thing. And we bat heads.

We have the opportunity to interchange views, expressing programmatic needs, capital needs, as well as both expressing "How much can the community afford?"

Our system, and part of the strength of the negotiating process, calls for an independent arbitrator to resolve differences if we can't do it. And I think because of that system—not the big-brother approach that Government is just going to set it, but a system that says to all of us as parties, "If you guys can't find the answer, you're going to go to an individual that will"—I think that has fostered good, firm negotiations and has brought most of the time a resolution of either a statewide maxi cap for the last 12 years or individual budget negotiations achieved through the negotiating process and not resorting to the legalistic approach.

The third item I would like to stress, which has been said repeatedly, and I don't want to belabor it by any stretch of imagination, is the idea that the prospective system does provide management incentives. I, my medical staff, and my trustees have super incentives in our system in Rhode Island to go out there and do a very efficient job, because I've got more needs there in that institution than my community can afford in any one given year; and, therefore through the incentive of efficiencies for myself, my physicians, and my department directors, we can meet some of those needs by cranking up a little harder.

So I think it is vital that we retain that incentive, that I can look at it at a bottom-line P. & O. statement, that it becomes a driving force. I am not after and I don't need profit—I need resources to meet my community needs, and the system that allows me to do that through management incentives is what I think you have got to keep.

I would also say that the system in Rhode Island helps redirect health care. We deliberately designed things so that we would develop a shift from inpatient to outpatient by providing more financial incentive if you have volume increases in the outpatient area instead of the inpatient area.

In my own institution we instituted a home-care program, we have a 1-day surgery program, and we have an outstanding residency program in family medicine to meet the clinical outpatient needs of our community. The system, again, provided those vehicles.

I think, in essence, I have covered what I would say, as John said, we recognize that we probably have a big plus in Rhode Island because we are small geographically. It is kind of easy for all of us to get together, we know one another in so many different arenas; but I do think that the system that we have can philosophically be overlaid in the other communities and include the key components of the partnership of the public and private sector, the negotiations of banging heads, and incentives to redirect the system.

Thank you very much.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Fransis R. Dietz follows:]

Testimony by Francis R. Dietz, President of
The Memorial Hospital, Pawtucket, RI, to the Senate Finance Committee
Relative to Exploration of Mandatory Rate Setting Legislation

I sincerely appreciate the opportunity to provide to the Senate Finance Committee my views relative to the exploration of a mandated rate review system of hospital cost and charges throughout the country.

In Rhode Island, a system of prospectively determining payments to hospitals by major third parties, i.e., Blue Cross, state government, and, for a period of three years, the federal government, has existed since 1970.

Before addressing the salient features of the Rhode Island system, I must point out the fact Rhode Island's rise in hospital costs has been at a rate of 3 to 5 percent below that of the national average during the past ten years. While we as hospital representatives are pleased at this result relative to cost constraint, we are equally pleased to be able to say that during this same period the quality of medical care delivered to the residents of Rhode Island has been enhanced. The designing of any system that solely addresses the cost side of the ledger and ignores quality would be a grave injustice to the citizenship.

The single most quality-related development that has taken place in Rhode Island during this period is the establishment of a medical school, even though the hospitals' performance relative to cost increases was below the national average. The establishment of a medical school in any community entails large expenditures for health care; however, improvements in the quality of services provided to the citizenship more than justifies these expenditures.

The above results have been achieved only through Rhode Island's prospective reimbursement system. Additionally, hospitals in our state have been able to complete major capital projects for the housing of our medical programs, as well as being able to establish many needed service programs for our patients.

The major point that I would like to leave with you relative to the Rhode Island system is that while costs have been constrained, quality has been enhanced.

The reason for the success in Rhode Island stems from the fact that from the very beginning the hospitals in our state voluntarily and enthusiastically supported a change to our reimbursement system. Hospital trustees, administrators, and physicians are truly concerned about the cost of health care and have constantly attempted to stem its growth while discharging their responsibilities for maintaining high quality care.

The system of prospective reimbursement for hospital services was not mandated in Rhode Island by our General Assembly, but instead was formulated through the voluntary and cooperative concerns of our hospitals and Blue Cross of Rhode Island. In 1970, we collectively developed a system of prospective reimbursement and in 1972, the state budget office was included in this process. The system in Rhode Island has succeeded because all parties involved in the payment and delivery system--hospitals, third-party purchasers, and state government--have had a direct say in the design of the system and thus a direct responsibility for the outcome. Authority without accountability will never succeed.

The responsibility of cost versus quality was placed squarely on the shoulders of the hospitals and major third-party purchasers, and the challenge was to design a system that would achieve both ends. By being architects of the system, all parties stood accountable to their communities for the successful outcome.

The mandatory rate setting approach would, in my opinion, allow the parties to divide themselves into different camps, each blaming the other for the lack of quality or the exorbitant cost. This process could result in a more legalistic outcome, since parties would tend to polarize and turn to the court system for resolutions. A voluntary partnership approach between private and public sector can result in an effective answer to the cost versus quality syndrome and should become a guide to developments in other parts of this country.

The regulation of any activity does not breed enthusiasm, but the placing of responsibility on those directly involved will produce the desired results.

The process which is the heart of the Rhode Island system lies in the concept known as negotiation. Negotiation brings to the table all parties to the problem, allowing a setting for true dialogue, expressions of disagreement and, finally, resolution.

The first step of negotiation is the establishment of a contract, which consists of the rules and regulations by which the system operates. The next step of the process annually determines the growth in hospital expenditures by taking into account the medical needs of the community, as well as the community's ability to afford the enhancement. Hospitals then negotiate their share of these expenditures by addressing medical programs needed for their institutions as well as capital programs approved through certificates of need.

Finally, if the results of negotiations fail to produce the desired end of a hospital's expense level for a given year, then a voluntary appeals mechanism of mediation and arbitration will decide which party is most responsible in its position.

True negotiations are the cornerstone in this process, with all parties standing accountable for the outcome. A mandated regulatory system could not accomplish the same end, since the body setting the rates would not stand accountable to the individual patients receiving the care. However, a system

that allows all parties equal participation in negotiations, with final resolution being placed in the hands of an independent arbitrator, jointly selected, fosters a spirit of cooperation and compromise. Rhode Island has achieved that end.

The final point I would like to discuss relative to the Rhode Island system is that of institutional incentives. The system in Rhode Island results in a firm fixed selling price for services rendered in a given year. Once these rates have been negotiated, it becomes the hospital's responsibility to manage within its budgeted revenues. If a hospital's expenditures exceed revenues, losses are born 100 percent by that institution. However, if hospitals, through management initiatives are able to achieve savings within available revenues, reallocation of these savings can be made to our many needed medical programs and services. The accountability of bottom-line profit and loss becomes a driving force for hospital efficiency and is a major reason why a medical school was developed in Rhode Island at a time when cost has been kept below the national average.

The trustees, medical staff, and administration of hospitals in Rhode Island have a tool in place for dealing with the cost versus quality issue. Through the collective development of hospital efficiencies, the resources saved can be channeled to needed medical services without increasing the cost of medical care. Management incentives must be an integral part of any successful payment system.

The system of prospective reimbursement developed for Rhode Island could not be applied in its entirety throughout the country. The reason for this stems primarily from the fact that Rhode Island is small geographically, thus promoting an ease in which all parties can join together. However, the essential components of the Rhode Island system, namely volunteerism of the private and public sector, negotiations, and management incentives, can be included in all locations.

This approach as opposed to a mandatory rate setting system can result in cost restraints while continuously improving the quality of services rendered.

The key component to a prospective reimbursement system is the combination of authority with accountability.

Senator DURENBERGER. All of your written statements will be made part of the record. Because of the press of time I am going to submit questions to each of you.

I would also appreciate your advice on some of the ancillary issues such as State or community health planning, utilization review, the PSRO system, tax-exempt bond financing, and the federalization of medicaid. I recognize that we have a responsibility to the needy as well as the elderly; yet, I think that responsibility might be better discharged at the State level.

[The questions follow:]

I regret the fact that we have run out of time. Thank you very much for the time that went into your preparation and for being here today.

The hearing is adjourned.

[Whereupon, at 4:20 p.m., the hearing was adjourned.]

[By direction of the chairman the following communications were made a part of the hearing record:]

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

The American Hospital Association (AHA) appreciated the opportunity to present its views on the issue of state rate review for hospitals. AHA represents over 6,300 member institutions, including most of the nation's hospitals, and over 35,000 personal members.

State rate review is not a sound alternative for addressing hospital cost increases. While such review has resulted in temporary benefits in some states, it poses numerous potential problems. These include:

Failure to address the demand side of health care costs;

Creation of ponderous bureaucracies with unwieldy reporting systems;

Unfair preferences for certain payors, which create inequities;

High costs of operating rate review agencies, complying with their regulations, and resolving through litigation the inequities they create;

Rates so low that hospitals deplete their capital resources, jeopardizing their future financial stability, their ability to serve the poor, and their very existence; and

Revenue controls without cost controls.

AHA opposes mandated state rate review and urges this committee to reject any cost-cutting proposals based on its principles. Hospitals are already burdened with complex regulations and a massive federal bureaucracy in the provision of Medicare and Medicaid services. A program of mandated state rate review would add yet another level of regulation and bureaucracy that would further involve government bureaucrats in hospital management. It would veer away from the goals of deregulation and changed incentives in the health care system.

The solution to rising health care costs lies not in increasing government intervention, but rather in placing control back where it belongs—in the hands of hospital management and consumers—with proper financial incentives for controlling costs and expenditures. The AHA's prospective payment proposal for Medicare, which was released in April and distributed to members of your Committee, deals with both the supply and demand sides of the equation for Medicare. prospective payment would control hospital cost increases by determining in advance the amount of money hospitals would receive for treating Medicare patients. The present Medicare cost-reimbursement system provides disincentives for hospitals to control costs. The more services a hospital provides, the greater its payments from Medicare. The AHA proposal would allow hospitals to elect annually whether to accept Medicare's price as payment in full (known as "assignment"), or to bill patients, within limits, for the difference between that fixed price and their charges, thus increasing consumer choices and cost awareness.

We urge Congress to move directly to a simple, straightforward system of prospective payment of hospitals for Medicare, with waivers for a hospital, group of hospitals, or individual states for alternative prospective payment systems that offer a reasonable expectation of savings over a minimum of three years. To ensure fruitful, cooperative efforts under state programs, it would be important to provide waivers for state prospective payment programs only if they were approved by a majority of hospitals in the respective states.

To further deal with the demand side of the hospital cost equation, we urge Congress to enact legislation that would create other incentives for consumers to make cost-conscious health care decisions. Consumers have been insulated from the true costs of their health care decisions through extensive first-dollar health insurance coverage and tax policies promoting such coverage. Legislative changes that could increase consumer cost-consciousness and reduce demand for health services include limiting the tax-free status of employer-provided health insurance; encouraging employers to offer a choice of types of health insurance coverage; and adopting a Medicare voucher system.

AHA's opposition to state rate review is fairly recent. Prior to 1980, AHA had supported federally-mandated state rate review as the best method for moving to a prospective payment system that would meet the financial requirements of hospitals. In 1980, after several years of experience with state rate review programs, the AHA House of Delegates voted to reverse its position of the issue. The House of Delegates determined that state rate review was "an idea whose time has come and gone" and that state rate review is an impediment to achieving a better system of reimbursement.

In Colorado and Illinois, each state's hospital association had been instrumental in enacting state legislation to create hospital rate review commissions. After experiencing the actual operation of the commission in the case of Colorado, and the plans for operation in the case of Illinois, the hospital associations took the lead in efforts to abolish the commissions.

In Colorado, the rate review program enacted in 1977 became a bureaucratic nightmare. The commission became ensnarled in regulations, politics, commission budgets, and granting of discounts for certain payors. Rates were set that threatened the continued existence and development of some hospitals. The Colorado commission was terminated in March 1980 by the state legislature. The experience cost Colorado hospitals an estimated $1.8 million in compliance costs in the first year. In Illinois, a similar scenario has played out. Illinois decided it could not afford the cost of rate review. Also, the system developed in Illinois would have resulted in inequitable and preferential payments. Statements of the Colorado Hospital Association and the Illinois Hospital Association of their own experiences with state rate setting are attached to this statement as Appendix A and Appendix B.

Development and operation of state rate review systems is very costly. Because of this and the increasing competition for state tax dollars, hospitals are concerned about the commitment of state legislatures to fund regulatory agencies with adequate and capable staff who understand both the needs of the community and the requirements of hospital management for quality health care delivery.

AHA defines the financial requirements of a hospital as the resources that not only are necessary to meet current operating needs, but also are sufficient to permit replacement of physical plant when appropriate and to allow for changing community health and patient needs, necessary education and research, and all other essentials for the institutional provision of health care services. The two basic components of hospital financial requirements are: (1) current operating funds and (2) an operating margin or return on equity. Hospitals cannot operate at a break-even level at which only operating expenses are recovered. In order to meet the total financial requirements of an institution, a margin of total operating revenue in excess of current operating requirements must be maintained. This operating margin provides the necessary funds for working capital and capital requirements for health care institutions and for providing care to patients who are unable or unwilling to pay their bills.

AHA's Office of Public Policy Analysis has prepared a comprehensive report on the effectiveness of state rate review using the latest available research findings and state-level data. This report is attached as Appendix C. It indicates that while the success of rate-setting states in controlling hospital costs may be affected by many outside factors influencing costs and by wide variations between individual states' experiences, one point is clear: Hospitals in rate review states as a whole have significantly narrower operating margins than hospitals in nonregulated states.

As indicated in Appendix C in Tables 7-11 on total revenue margins and in Tables 12-16 on patient revenue margins, hospitals in rate review states appear to be consuming their capital to a greater extent than hospitals in the rest of the nation. These figures raise serious questions concerning the ability to meet current and future service needs; the possibility of some hospitals being forced to limit access to all citizens and reduce quality of care; and the long-term financial stability and survival of some hospitals in rate review states.

While some in Congress have suggested a system of mandatory state rate review for hospitals, we find it unlikely that Congress would be willing to fully turn over the establishment of Medicare rates to the states—not when Congress must raise the funds to pay the more than $50 billion Medicare bill. Instead, Congress would be more likely to require that states operate under a Medicare "cap" established by the federal government. This has been the case in New Jersey, a state that has a waiver from the Health Care Financing Administration allowing it to set rates for Medicare as well as other patients. The Medicare cap in New Jersey places a penalty on the hospital rather than the state rate authority when Medicare costs exceed what would have been paid to a hospital by Medicare without the waiver. There is no risk to the federal government, nor to the state—only to the hospitals.

In conclusion, neither state rate review nor arbitrary cuts in payment to hospitals proposed in the Fiscal Year 1983 budget plan is the answer to the problem of rising hospital costs. Both approaches only would tend to reduce payments to hospitals, not reduce hospital costs. Such approaches fail to recognize the impact of the physician on use of services and the insulation of patients from the costs of health care decisions made on their behalf.

We urge this committee to move rapidly to a system of prospective payment for Medicare along the lines of AHA's proposal and to enact appropriate tax and consumer-choice legislation to make health care consumers more cost-conscious. Both supply and demand must be dealt with, if the solution is to be lasting.

[Appendix A]

Statement of the Colorado Hospital Association

THE COLORADO EXPERIENCE—THE CREATION AND THE DEMISE OF A STATE HOSPITAL COMMISSION

The issue of increasing health care costs, particularly hospital costs, has been of concern in Colorado as much as it has in other parts of the country. Like too many people in the health care field, the hospital industry in Colorado chose not to address the problem within the industry where the real expertise was, but rather went running to the government to solve it problems. The government in this case was the Colorado General Assembly.

Although some in the Colorado General Assembly were wise enough to see that the government not only would be unable to resolve the problem, but would no

doubt compound it, the hospitals and other allies were able to prevail. As a result, the Colorado Hospital Commission was born on October 1, 1977.

At this point, the issue of health care costs began to dim and the politics of who was going to control hospital prices dominated the issue. No longer were hospital costs and sources of reimbursement the key questions, but rather the questions of who the commissioners were going to be, what should their political party be, how much should the commission budget be, by whom and how was the commission's budget going to be funded?

With these weighty problems answered, did the focus then turn back to the questions of health care costs and reimbursement methods? Absolutely not! As is always the case when governments step in, the next most important issue to be resolved was how to determine and set up rules and regulations. Months went by and hearings dragged on. Third-party insurers of health care demanded discounts from the hospitals written into the regulations. HMOs wanted guarantees of special considerations from the hospitals based on their unique type of delivery. The state already had exempted itself from participation in the Medicaid program, so was no longer in need of special recognition through rules and regulations. In addition, every special interest group in and out of the hospital industry lobbied for its particular issue. No two groups could ever agree.

During adversarial hearings, hospitals tried to ascertain what they were to report, when they were to report, and how they were to do the reporting. The deadline for the first hospital to report had come and gone, yet the rules, regulations, and forms for reporting were still unsettled.

Finally, hospitals were able to get a picture, fuzzy though it was, of what was expected of them. This was not a pretty picture—four very negative rules, from the hospitals' perspective, were advanced. First, the hospitals were not going to be allowed to have any income greater than their expenses, which meant that their very financial existence was being challenged. Second, there would be no budgetary allowance for growth and development. Thirdly, new services, resulting from medical advances, would have to pay their way from the very start due to a disallowance of cross-financial subsidization for new programs. Lastly among the four major punitive rules, the hospitals were mandated to give a 3 percent discount to Blue Cross and qualified HMOs in addition to a 2 percent discount for prompt payment by purchasers.

Faced with these formidable problems, along with many more minor ones, and uncertain as to what and in what manner information was required, the hospitals had no avenues left except the courts. When the commission realized the degree of dissatisfaction the hospital industry had and the industry's resolve to face the regulation issue head on, it agreed to reopen hearings on the regulations if the hospitals would drop their suit.

The hospitals agreed and dropped their suit and new hearings were scheduled. However, the second round of hearings became the same battlefield for the same groups. It became evident that the only route, short of a very lengthy and costly court suit, was to present the hospital case to the body of government that created the commission—the state legislature.

When the fruits of their legislative efforts were brought back in the form of testimony from those impacted by the law, legislators were quick to realize that these fruits were grown from bad seed and their only recourse was to uproot the commission in its entirety. A "sunset" provision was amended onto the statute in 1979 after a one-year effort to make the statutory rate system work. This put everyone on notice to make it work. If they failed, the legislature would abolish it. Even under this very clear mandate to work out differences, all those involved were still unable to develop a workable program. On March 1, 1980, The Colorado Hospital Commission died.

The lessons learned in Colorado are simple. No industry, hospitals included, can expected to go to the government and have it solve problems that the industry must solve itself. Also, statutory requirements breed bureaucracies that become self-serving, "politics" become more important than the problem, and the cost of meeting the law, rules, and regulations generally more than offsets the savings. Colorado found also that until the demand side of the health care formula is addressed, it is foolish to play with the reimbursement side.

Finally, the hospitals found that under a hospital rate commission the only alternative for meeting their immediate financial needs was to exhaust their reserves and place themselves at a long-term financial risk. With the options of either changing the law or engaging in long and expensive litigation, it was only prudent for the industry to support a change in the law. As it turned out, the legislature found that

the best way to meet its public obligations was not to change the law but to do away with it.

[Appendix B]

Statement of the Illinois Hospital Association

The elected leadership of the Illinois Hospital Association first endorsed the concept of prospective rate review in 1969. Since then, administrative and legislative initiatives to develop a formal program have been undertaken with three Illinois governors. In September, 1978, Governor James Thompson signed into law Public Act 80-1427, an act which created the Illinois Health Finance Authority to overree the orderly establishment and payment of hospital rates in Illinois.

Since the time that IHA and representatives from Illinois hospitals, commercial insurance companies, the two Blue Cross plans, various state agencies and the Governor worked with the legislature to devise the language for the Illinois rate setting program, much has happened to convince the hospital industry that the state is no longer willing or able to participate equitably in a reasonable program.

Illinois hospitals reversed their position on the desirability of having a rate review system in the state for two reasons. First, the recession and other developments in Illinois made this state's equitable financial participation an impossibility. In late 1980 the Illinois Department of Public Aid took steps to redefine certain components of the system to eliminate a portion of hospital financial requirements which would have otherwise been apportioned to them. Hospital-based skilled nursing facilities and home health agencies are but two examples of hospital operations which have been defined as non-hospital services by the rate review agency at the request of the state. The fact that a prospective payment system such as the one developed in Illinois would cost the state more money than the current Medicare/Medicaid retrospective approach became even more apparent when shortfalls of $106 million and $300 million respectively developed in the state's medical assistance budget for hospitals for Fiscal Years 1982 and 1983.

Secondly, the rate review agency violated its own enabling statutes with respect to the granting of differentials in its efforts to entice the federal government to waive Medicare principles of reimbursement for the Illinois hospitals and participate in the prospective rate setting experiment. When hospitals realized that the rate review agency would not produce an equitable payment system, but would simply be a new approach to perpetuating the cost-shifting inequities of the current system, their trust in the system diminished and they felt that the only course of action was to withdraw their support from the experiment.

For almost four years, the Illinois Health Finance Authority has attempted to implement a system that does not make sense, is unduly complex and ignores the preponderance of the input it has received from Illinois hospitals. In many cases the Authority is at odds with the mandate it received from the Illinois General Assembly. An attitude of "what you see is what you are going to get" from the agency and its unwillingness to deal in good faith with hospitals makes it quite apparent that the system must be abandoned to prevent a rapid downhill slide in the quality and access to hospital care.

[Appendix C]

Office of Public Policy Analysis, American Hospital Association Report on State Hospital Rate Regulation

INTRODUCTION

Several state governments operate programs to regulate hospital payment rates. This report discusses current information, and gaps therein regarding the effectiveness of this approach to health care cost containment. The laterst available research findings and state-level data on the cost and other impacts of state hospital rate regulation programs are presented, along with a series of overall conclusions.

States have been categorized in various ways in studies of hospital rate regulation. Most studies, however, include the following six states in the regulated category: Connecticut, Maryland, Massachusetts, New Jersey, New York, and Washington. The Biles team identify these six states as meeting the following criteria: the rate-setting program is operated directly by state government, hospital compliance is re-

quired, and a majority of non-Medicare expenditures are regulated.[1] These six states are singled out for discussion in this paper.

AVAILABLE DATA AND RESEARCH FINDINGS

Available data and research findings are extremely mixed and inconclusive regarding the effects of state rate review.

Cost impacts

Based on the latest nationally available state-level cost data (1975–80), while the combined results of the six states compare favorable with the rest of the nation in terms of average annual growth in inpatient expense per admission and per capita (see Tables 1 and 2) between 1976 and 1980, the individual cost results of the six states varied widely at any point in time and over time in comparison to the national experience (see Tables 3–6).

In none of the regulated states was performance steady or steadily improving relative to trends in other states.

For Maryland, impatient cost per capita increased more rapidly than the U.S. average for three of the five years.

For Connecticut, Massachusetts, and New York, growth rates in inpatient cost per admission became less favorable relative to U.S. averages during 1979 and 1980.

In 1980, Massachusetts and New York had higher inpatient cost per capita than all but two of the 50 states.

In 1980, the ten states with the lowest rate of increase in cost per admission included five regulated states and five non-regulated states: Alaska, Delaware, Nebraska, Michigan, and Idaho.

Even with respect to the narrow issue of cost impacts, studies to date have varied widely in terms of scope and findings.

Of the early studies financed by the Social Security Administration, the private sector rate review program in Indiana showed strongest cost containment results of the five programs studied.[2]

The Melnick team,[3] using more recent data than earlier studies, reported evidence that rate regulation nationally was less effective in containing costs in 1979 than in 1978.

A recent study by Abt Associates,[4] more refined than the earlier GAO study,[5] found that individual mandatory rate regulation programs were not necessarily more effective in containing costs than the voluntary programs examined.

While the studies by Sloan,[6] Joskow,[7] the Melnick team, Abt Associates, and Sloan and Steinwald,[8] more carefully account for outside factors that may affect cost results in states with rate review programs than the GAO, CBO,[9] and Biles team[5] studies, typically there has been no explicit control for various private sector cost containment initiatives and factors at play within such states (e.g., changes in private health insurance benefit structures, voluntary areawide health planning efforts, and private insurer and business utilization review efforts).

The administrative and legal costs of rate regulation have generally been ignored, as have the potential cost consequences of any service supply and utilization growth outside the hospital domain[10] as a result of state rate review programs.

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[1] B. Biles, C. Schramm, and J. Atkinson, "Hospital Cost Inflation Under State Rate-Setting Programs," New England Journal of Medicine (September 18, 1980) pp: 665–668.

[2] D. Salkever, Hospital-Sector Inflation (Lexington, MA: Lexington Books, Health and Co., 1979) pp: 123–178.

[3] Glenn A. Melnick, John R.C. Wheeler and Paul J. Feldstein, "Effects of Rate Regulation on Selected Components of Hospital Expenses," Inquiry 18: pp: 240–246 (Fall 1981)

[4] C. Coelen and D. Sullivan, "An Analysis of the Effects of Prospective Reimbursement Programs on Hospital Expenditures," Health Care Financing Review 2 (3): pp: 1–40 (Winter 1981).

[5] General Accounting Office, "Rising Hospital Costs can be restrained by Regulating Payments and Improving Management" (Washington: Government Printing Office, September, 19, 1980).

[6] F. Sloan, "Regulation and the Rising Cost of Hospital Care, "Review of Economics and Statistics, forthcoming.

[7] P. Joskow, "Alternative Regulatory Mechanisms for Controlling Hospital Costs," Paper presented at the American Enterprise Institute Conference: Health Care—Professional Ethics, Government Regulation or Markets, Washington, D.C., September 25, 1980, pp: 8.5.

[8] F. Sloan and B. Steinwald, "Insurance, Regulation and Hospital Costs" (Lexington, MA: Lexington Books, Health and Co., 1980) pp: 107–113.

[9] Congressional Budget Office, "Controlling Rising Hospital Costs" (Washington: Government Printing Office, September, 1979) pp: 94–96.

[10] This discussion is based largely on: Morrisey, Michael A., Ph.D., "Hospital Rate Review: The State of the Empirical Knowledge," working draft, Hospital Research Center, American Hospital Association, October, 1981.

Other impacts

The current literature offers little insight into the short- or long-range impacts of rate regulation on the accessibility, scope, and quality of health care services.

Quality impact studies are severely hampered by the lack of comprehensive, generally accepted measures of quality.

One of the five prospective payment studies sponsored early in the 1970s by the Social Security Administration, the downstate New York evaluation, reported increases in the number of hospitals receiving provisional accreditations by the Joint Commission on Accreditation of Hospitals.[10]

One part of the National Hospital Rate Review Study, sponsored by HHS' Health Care Financing Administration and soon to be reported, is a study of hospital service scope under rate review. The University of Washington and the AHA have recently begun a study, funded by the National Center for Health Services Research, to assess the effects of rate regulation on hospital organization and operations.

Levels and trends in hospital revenue margins represent a key measure of the future ability of hospitals to maintain and improve quality and accessibility of services for all population groups, particularly the poor. On this score, rate review programs raise serious public policy concerns.

As indicated in Tables 7–11 on total revenue margins and in Tables 12–16 on patient revenue margins, hospitals in rate review states appear to be consuming their capital to a greater extent than hospital in the rest of the nation.

For the six states individually and as a group, aggregate patient and total revenue margins were, generally, significantly below those experienced in the rest of the nation as a whole.

For the six states as a group, the percent of hospitals with deficits greater than 0.5 percent decreased between 1975 and 1980, but not as much as for the rest of the nation.

In New York, hospitals have on average consistently operated at a deficit, even considering revenue from both operating and nonoperating sources. The average deficit has ranged from 0.2 percent to 8.4 percent, and was under 1 percent only once during the six years.

Where revenue margins are deteriorating under state rate regulation, either the programs have not really been able to change the economic behavior of consumers in demanding health care or the behavior of providers, or they have expected through revenue constraints far more than can be accomplished. In either case, the end result is merely a short-run gain for payers. In an environment of increasingly limited payer budgets, especially state Medicaid program budgets, the danger is that short-term results—no matter how arbitrary—become the overriding objective of such programs, with a generally bankrupt hospital the long-term consequence. Squeezing hospital revenues, without effectively and equitably containing costs, only forces hospitals to consume their capital. That capital is crucial to the hospital's future ability to replace or improve itself and to meet a variety of needs of patients, particularly those least able to pay for care.

CONCLUSIONS

Formal evaluations of the impacts of state rate review programs lack consensus even on cost impacts, are generally incomplete in scope, pose various methodological problems in study design and assumptions, and/or are outdated. More and better studies are needed to reach definitive conclusions.

Less formal evaluations indicate that even from the narrow perspective of hospital cost levels and trends, individual rate review programs show uneven results at any point in time and over time in comparison to non-rate review states.

With regards to hospital revenue margins—a key indicator of the general financial health of institutions and of their ability to generate and attract capital to meet current and future service needs of all population groups, including the poor—state rate review programs pose serious concerns. These concerns become even more acute if future decisions on rates under rate review programs become based not on what well-managed hospitals need to stay financially healthy and viable, but on what state Medicaid programs can afford at any point in time from a budgetary standpoint.

Additional concerns are whether such programs stifle payment and service delivery innovations and unnecessarily infringe on hospital management prerogatives.

The key point is that there has not yet been indentified one best hospital payment method or methods for widespread use over the long term.

As a result, the AHA's Medicare prospective fixed price payment proposal suggests only a specific short-term approach and simultaneously calls for expanded

waiver opportunities for groups of hospitals and states to develop and apply their own innovative approaches. The best, longer-term approaches will be derived from local genius and imagination linked to unique local circumstances and needs. In some locales, customized state rate review programs may be the appropriate long-term solution. In many other locales, a variety of nonregulatory solutions may be selected. Generally, state hospital rate regulation will be viewed, and appropriately so, as the alternative of last resort.

Regardless of the approach selected, it must result from the joint, cooperative efforts of all the involved parties if it is to be both equitable to hospitals and effective in restraining cost increases. In the AHA's Medicare prospective payment proposal, state-sponsored alternative prospective payment systems cannot be waived by the Secretary of HHS that do not have the majority support of hospitals in the state. A partnership approach to payment reform is essential.

TABLE 1.—INPATIENT EXPENSE PER ADMISSION FOR COMMUNITY HOSPITALS

[Percent change in parenthesis]

Year	6 regulated States	Other States
1976	$1,523(8.5)	$1,085(14.6)
1977	1,690(11.0)	1,238(14.1)
1978	1,842(9.0)	1,392(12.4)
1979	2,009(9.1)	1,558(11.9)
1980	2,232(11.1)	1,770(13.6)
Annual average	(9.9)	(13.3)

Source: American Hospital Association, "Annual Survey of Hospitals" 1975–80 editions.

TABLE 2.—INPATIENT EXPENSE PER ADMISSION FOR COMMUNITY HOSPITALS

[Percent change in parenthesis]

Year	6 regulated States	Other States
1976	$217(4.6)	$178(15.1)
1977	241(10.8)	203(13.9)
1978	260(7.9)	228(12.3)
1979	286(10.0)	256(12.6)
1980	317(11.1)	299(16.5)
Annual average	(8.8)	(14.1)

Source: American Hospital Association, "Annual Survey of Hospitals" (1975–80 editions).

TABLE 3.—INPATIENT EXPENSE PER ADJUSTED ADMISSION FOR COMMUNITY HOSPITALS

[Percent change from previous year]

	State	United States	Gap
New York:			
1976	3.0	13.0	10.0
1977	12.8	13.6	0.8
1978	8.7	11.5	2.8
1979	8.6	11.3	2.7
1980	10.98	13.1	2.1
Massachusetts:			
1976	15.64	13.0	−2.6
1977	12.41	13.6	1.2
1978	8.91	11.5	2.6
1979	7.67	11.3	3.6
1980	13.93	13.1	−0.8
New Jersey:			
1976	13.4	13.0	−0.4
1977	10.8	13.6	2.8
1978	9.3	11.5	2.2
1979	10.8	11.3	0.5

TABLE 3.—INPATIENT EXPENSE PER ADJUSTED ADMISSION FOR COMMUNITY HOSPITALS—Continued

[Percent change from previous year]

	State	United States	Gap
1980	10.7	13.1	2.4
Connecticut:			
1976	13.12	13.0	−0.1
1977	11.2	13.6	2.4
1978	9.8	11.5	1.7
1979	8.1	11.3	3.2
1980	11.3	13.1	1.8
Washington:			
1976	15.9	13.04	−2.9
1977	12.8	13.6	0.8
1978	11.3	11.5	0.2
1979	10.7	11.3	0.6
1980	11.13	13.08	2.0
Maryland:			
1976	14.4	13.0	−1.4
1977	8.8	13.6	4.8
1978	9.3	11.5	2.2
1979	12.4	11.3	−1.1
1980	9.6	13.1	3.5

Source: American Hospital Association, "Annual Survey of Hospitals" (1975–80 Editions).

TABLE 4.—INPATIENT EXPENSE PER CAPITA FOR COMMUNITY HOSPITALS

[Percent change from previous year]

	State	United States	U.S. increase less State change
New York:			
1976	−2.9	12.5	15.4
1977	10.1	13.1	3.0
1978	6.7	11.3	3.7
1979	10.1	12.0	1.9
1980	9.3	15.4	6.1
Washington:			
1976	13.1	12.5	−0.6
1977	12.0	13.1	1.1
1978	7.4	11.3	3.9
1979	8.9	12.0	3.1
1980	24.7	15.4	−9.3
New Jersey:			
1976	16.0	12.5	−3.5
1977	12.4	13.1	0.7
1978	8.5	11.3	2.8
1979	10.9	12.0	1.1
1980	12.1	15.4	3.3
Connecticut:			
1976	14.5	12.5	−2.0
1977	10.7	13.1	2.4
1978	9.3	11.3	2.0
1979	9.2	12.0	2.8
1980	12.0	15.5	3.4
Maryland:			
1976	18.1	12.5	−5.6
1977	10.5	13.1	2.6
1978	12.1	11.3	−0.8
1979	15.3	12.0	−3.3
1980	8.8	15.4	6.6

TABLE 4.—INPATIENT EXPENSE PER CAPITA FOR COMMUNITY HOSPITALS—Continued

[Percent change from previous year]

	State	United States	U.S. increase less State change
Massachusetts:			
1976	7.4	12.5	5.1
1977	11.5	13.1	1.6
1978	6.9	11.3	4.4
1979	8.2	12.0	3.8
1980	10.0	15.4	5.4

Source: American Hospital Association, "Annual Survey of Hospitals" (1975–80 Editions).

TABLE 5.—INPATIENT EXPENSE PER ADMISSION FOR COMMUNITY HOSPITALS

State	1980 expense level	Rank	Percent change	Rank
Alabama	$1,467	(38)	14.0	(16)
Alaska	2,292	(5)	1.6	(51)
Arizona	2,020	(12)	15.9	(9)
Arkansas	1,175	(51)	12.3	(36)
California	2,400	(4)	14.6	(15)
Colorado	1,727	(22)	13.2	(27)
Connecticut	2,045	(11)	11.3	(42)
Delaware	1,946	(14)	8.0	(50)
District or Columbia	3,186	(1)	17.0	(5)
Florida	1,808	(20)	12.0	(31)
Georgia	1,381	(43)	12.4	(34)
Hawaii	1,849	(16)	12.1	(40)
Idaho	1,254	(48)	11.3	(42)
Illinois	2,202	(7)	17.4	(4)
Indiana	1,622	(26)	14.0	(16)
Iowa	1,474	(36)	12.2	(39)
Kansas	1,591	(27)	15.0	(13)
Kentucky	1,276	(46)	15.5	(11)
Louisiana	1,487	(33)	12.9	(30)
Maine	1,713	(23)	15.0	(13)
Maryland	2,138	(9)	9.6	(48)
Massachusetts	2,579	(2)	13.9	(20)
Michigan	2,081	(10)	10.3	(47)
Minnesota	1,808	(19)	13.4	(25)
Mississippi	1,187	(50)	12.3	(36)
Missouri	1,845	(18)	13.5	(22)
Montana	1,326	(45)	13.5	(22)
Nebraska	1,526	(31)	9.3	(49)
Nevada	2,213	(6)	22.6	(1)
New Hampshire	1,457	(39)	11.9	(41)
New Jersey	1,851	(17)	10.7	(46)
New Mexico	1,543	(28)	21.4	(2)
New York	2,472	(3)	11.0	(45)
North Carolina	1,399	(41)	12.3	(36)
North Dakota	1,541	(29)	13.5	(22)
Ohio	1,910	(15)	14.0	(16)
Oklahoma	1,543	(30)	14.0	(16)
Oregon	1,665	(24)	13.0	(29)
Pennsylvania	1,964	(13)	13.1	(28)
Rhode Island	2,166	(8)	12.6	(32)
South Carolina	1,366	(44)	17.0	(5)
South Dakota	1,272	(47)	16.4	(8)
Tennessee	1,424	(40)	15.3	(12)
Texas	1,493	(34)	13.6	(21)
Utah	1,471	(37)	21.3	(3)
Vermont	1,476	(35)	13.3	(26)

TABLE 5.—INPATIENT EXPENSE PER ADMISSION FOR COMMUNITY HOSPITALS—Continued

State	1980 expense level	Rank	Percent change	Rank
Virginia	1,645	(25)	12.4	(34)
Washington	1,510	(32)	11.1	(44)
West Virginia	1,397	(42)	15.8	(10)
Wisconsin	1,758	(21)	12.6	(32)
Wyoming	1,192	(49)	17.0	(5)

Source: American Hospital Association, "Annual Survey of Hospitals" (1975–80 editions).

TABLE 6.—RATE OF CHANGE IN INPATIENT EXPENSE PER CAPITA 1979–80

State	1980 expense level	Rank	Percent change	Rank
Alabama	$288	(19)	16.6	(20)
Alaska	216	(25)	5.6	(51)
Arizona	280	(24)	16.5	(21)
Arkansas	231	(39)	15.7	(27)
California	333	(7)	18.3	(15)
Colorado	263	(30)	14.9	(32)
Connecticut	276	(26)	12.0	(41)
Delaware	248	(34)	8.4	(50)
District of Columbia	737	(1)	14.2	(37)
Florida	313	(12)	10.3	(45)
Georgia	250	(33)	14.8	(34)
Hawaii	193	(50)	11.2	(42)
Idaho	185	(51)	15.9	(25)
Illinois	387	(3)	16.4	(23)
Indiana	271	(28)	16.5	(21)
Iowa	286	(20)	14.5	(35)
Kansas	305	(15)	16.9	(19)
Kentucky	234	(37)	18.3	(15)
Louisiana	292	(18)	20.1	(10)
Maine	272	(27)	14.4	(36)
Maryland	261	(31)	8.8	(48)
Massachusetts	374	(4)	10.0	(46)
Michigan	329	(8)	10.6	(44)
Minnesota	311	(13)	17.3	(18)
Mississippi	241	(35)	15.1	(31)
Missouri	359	(6)	18.7	(14)
Montana	224	(42)	16.3	(24)
Nebraska	281	(23)	11.2	(42)
New Hampshire	218	(44)	17.6	(17)
New Jersey	264	(29)	12.1	(39)
New Mexico	201	(48)	22.4	(7)
Nevada	401	(2)	41.4	(1)
New York	359	(5)	9.3	(47)
North Carolina	214	(46)	12.1	(40)
North Dakota	323	(11)	19.0	(13)
Ohio	325	(10)	15.7	(27)
Oklahoma	282	(22)	22.9	(5)
Oregon	257	(32)	20.3	(9)
Pennsylvania	326	(9)	14.9	(32)
Rhode Island	294	(17)	8.6	(49)
South Carolina	197	(49)	15.9	(25)
South Dakota	231	(38)	19.5	(12)
Tennessee	313	(14)	19.7	(11)
Texas	277	(25)	22.5	(6)
Utah	226	(41)	27.4	(3)
Vermont	221	(43)	13.3	(38)
Virginia	234	(36)	15.3	(28)
Washington	229	(39)	24.2	(4)

TABLE 6.—RATE OF CHANGE IN INPATIENT EXPENSE PER CAPITA 1979–80—Continued

State	1980 expense level	Rank	Percent change	Rank
West Virginia	303	(16)	21.1	(8)
Wisconsin	282	(21)	15.2	(30)
Wyoming	202	(47)	40.2	(2)

Source: American Hospital Association, "Annual Survey of Hospitals" (1975–80 editions).

TABLE 7.—TOTAL REVENUE MARGIN FOR COMMUNITY HOSPITALS[1]

[In percent]

Year	6 regulated States	Other States
1975	−3.57	2.09
1976	0.36	3.51
1977	−1.25	3.22
1978	−0.20	3.42
1979	−0.01	3.75
1980	0.50	4.39

[1] Total revenue margin = (Total net revenue − total cost)/total net revenue, where net revenue is net of deductions.
Source: American Hospital Association, "Annual Survey of Hospitals" (1975–80 Editions).

TABLE 8.—TOTAL REVENUE MARGIN FOR COMMUNITY HOSPITALS[1]

[In percent]

Year	Connecticut	Maryland	Massachusetts	New York	New Jersey	Washington	United States
1975	0.33	−0.14	1.01	−8.39	1.88	2.77	0.77
1976	0.87	1.00	0.29	−0.22	0.75	3.11	2.80
1977	1.36	0.48	0.10	−3.42	−0.01	4.20	2.24
1978	0.82	1.48	2.57	−2.90	1.72	5.03	2.66
1979	1.85	1.39	3.84	−2.90	0.79	5.25	2.97
1980	1.11	2.05	2.24	−1.17	−0.45	7.18	3.61

[1] Total revenue margin = (Total net revenue − total cost)/total net revenue where net revenue is net of deductions.
Source: American Hospital Association, "Annual Survey of Hospitals" (1975–80 Editions).

TABLE 9.—PERCENT OF COMMUNITY HOSPITALS WITH TOTAL REVENUE DEFICITS GREATER THAN 0.5 PERCENT

Year	6 regulated states	Rest of the Nation	The 6 States individually					
			Massachusetts	Connecticut	New York	New Jersey	Maryland	Washington
1975	27.6	23.9	17.9	21.6	35.1	16.2	24.5	30.1
1980	23.8	13.0	18.1	8.3	36.4	18.6	16.7	11.2
Decrease (increase)	(3.8)	(5.9)	.2	(13.3)	1.3	2.4	(7.8)	(18.9)

Source: American Hospital Association, "Annual Survey of Hospitals" (1975, 1980 editions).

TABLE 10.—DISTRIBUTION OF COMMUNITY HOSPITALS AMONG TOTAL REVENUE MARGIN CATEGORIES

[In percent]

Margin category	6 regulated States		Rest of the Nation	
	1975	1980	1975	1980
4.50 and above	15.9	20.9	30.0	41.6
1.50 to 4.49	25.6	22.9	23.7	24.0
0.50 to 1.49	11.2	10.4	10.0	6.8
−0.50 to 0.49	11.6	12.3	6.5	5.8
−1.50 to −0.49	8.2	9.7	5.8	3.8
−4.50 to −1.49	11.3	12.0	8.7	7.2
Below −4.5	16.3	11.7	15.2	10.8

Source: American Hospital Association, "Annual Survey of Hospitals" (1979, 1980 editions).

TABLE 11.—DISTRIBUTIONS OF COMMUNITY HOSPITALS AMONG TOTAL REVENUE MARGIN CATEGORIES

Margin category	Massachusetts		Connecticut		New York		New Jersey		Maryland	
	1975	1980	1975	1980	1975	1980	1975	1980	1975	1980
4.5 percent and above	11.4	17.2	10.8	11.1	12.5	12.0	20.0	9.8	18.4	27.8
1.50 to 4.49	34.1	32.8	18.9	30.6	22.9	15.6	28.6	31.4	22.4	25.9
0.50 to 1.49	13.0	14.7	16.2	25.0	10.3	9.5	14.3	10.8	10.2	13.0
−0.50 to 0.49	16.3	13.8	16.2	13.9	11.6	15.3	11.4	15.7	12.2	1.9
−1.50 to −0.49	7.3	3.4	16.2	11.1	7.5	11.3	9.5	13.7	12.2	14.8
−4.50 to −1.49	8.9	6.9	10.8	5.6	12.9	16.7	7.6	13.7	6.1	11.1
Below 4.5	8.9	11.2	10.8	2.8	22.3	19.6	8.6	4.9	18.4	5.6

Source: American Hospital Association, "Annual Survey of Hospitals" (1975, 1980 editions).

TABLE 12.—PATIENT REVENUE MARGIN FOR COMMUNITY HOSPITALS [1]

[In percent]

Year	6 regulated States	Other States
1975	−16.2	−5.3
1976	−8.4	−3.1
1977	−10.9	−3.2
1978	−9.9	−3.5
1979	−9.2	−3.2
1980	−8.6	−2.9

[1] Patient revenue margin = (net patient revenue − total cost)/net patient revenue, where net patient revenue is net of deductions.
Source: American Hospital Association, "Annual Survey of Hospitals" (1975–80 editions).

TABLE 13.—PATIENT REVENUE MARGIN OF COMMUNITY HOSPITAL [1]

[In percent]

Years	Connecticut	Massachusetts	Mary[illegible]	New Jersey	New York	Washington	United States
1975	−4.2	−18.2	−5.8	−5.1	−23.7	−2.9	−7.
1975	−3.8	−9.6	−7.4	−5.8	−10.4	−1.5	−4.
1977	−3.4	−12.8	−5.9	−7.0	−14.5	−0.8	−4.
1978	−4.3	−8.7	−5.0	−4.8	−13.7	−0.6	−4.
1979	−3.9	−6.5	−5.4	−6.5	−13.8	−1.0	−4.
1980	−4.5	−8.8	−3.9	−7.6	−11.6	−1.1	−4.

[1] Patient revenue margin = (net patient − total cost)/patient revenue, where net patient is net of deductions.
Source: American Hospital Association, "Annual Survey of Hospitals" (Editions 1975–80).

TABLE 14.—PERCENT OF COMMUNITY HOSPITALS WITH PATIENT REVENUE DEFICITS GREATER THAN 0.5 PERCENT

Years	6 regulated States	All nonregulated States	The 6 States individually					
			Connecticut	Maryland	Massachusetts	New Jersey	New York	Washington
1975	35.8	29.7	37.8	36.7	25.2	25.7	42.6	36.4
1980	33.5	21.8	19.4	31.5	21.6	32.4	47.6	16.8
Decrease (increase)	(2.3)	(7.9)	(18.4)	(5.2)	(3.6)	(3.3)	5.0	(19.6)

Source: American Hospital Association, "Annual Survey of Hospitals" (1975, 1980 editions).

TABLE 15.—DISTRIBUTION OF COMMUNITY HOSPITALS AMONG PATIENT MARGIN CATEGORIES

[In percent]

Margin category	6 regulated States		Rest of the Nation	
	1975	1980	1975	1980
4.50 and above	6.7	5.9	13.3	16.2
1.50 to 4.49	11.4	6.2	16.0	16.5
0.50 to 1.49	4.6	4.3	5.7	6.7
−0.50 to 0.49	5.7	6.1	5.6	7.2
−1.50 to −0.49	7.7	8.0	6.2	7.3
−4.50 to −1.49	21.9	22.9	15.3	16.1
Below −4.5	41.9	46.5	37.8	30.1

Source: American Hospital Association, "Annual Survey of Hospitals" (1975, 1980 editions).